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DL. 9 NO. 8

UGUST, 1960

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MARYLAND

STATE MEDICAL JOURNAL

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PRESIDENTIAL EDITORIAL

Among our chronic crises which afflict us almost daily, perhaps none is more disturbing to the medical profession than the serious decline in quantity and quality of those seeking medicine as a career. Only an average of 1.8 applications are received for each medical freshman position as compared with 5 just a few years ago. Recently the college grade averages of first year medical students were determined to be A, 16 per cent; B, 70 per cent; C 14 per cent. In 1951, A students constituted 40 per cent of the entering class. Scholastic standing is undeniably only one of a number of factors which determine the suitability of an applicant, as is so well exemplified by the excellent physicians and surgeons who had only average college grades. It is conceivable, however, that some increase in A students would provide for more original research and more authoritative teaching, thus helping to maintain American medical care at its high level.

Another facet of this problem relates to the reasonable assumption that we shall have to increase the number of annual medical school graduates from the present 7,000 to 10,000 by 1975 to meet the demands of a steadily increasing population. It may be noted, incidentally, that the 1975 goal is short of the number of internships available in the United States in 1960!

It is apparent that the idea of a medical career will now have to be sold to some of the high school or early college students who are being attracted by nuclear science, electronics, industrial chemistry, and other fields of a similar nature which offer social status and high income much earlier in life than is possible in medicine. The average full-time student for a Ph.D. degree in the sciences spends 7.5 to 7.8 years beyond high school, often at little or no expense beyond his undergraduate years because of grants, research projects, and teaching assignments. It requires from 9 to 15 years beyond high school to produce a doctor. The cost of our years of medical school alone is about \$11,600, and it is virtually impossible for the student to earn any substantial part of this amount.

To compete with the more attractive forms of endeavor, therefore, more scholarships and greater financial aid must be offered students of medicine, and the period of education and training must be shortened without affecting the quality of the members of our profession. A committee of the Americal Medical Association is preparing a plan for the establishment of 50 scholarships of about \$1000 a year for four years. This is a significant beginning. The Johns Hopkins University has shortened its education and training period for selected medical students by two years, and similar programs are being undertaken at the University of Vermont and at Northwestern University. If these programs are success-

ful enough to be adopted generally, they should help to attract more candidates for the degree of Doctor of Medicine.

The American Medical Association and the Association of American Medical Colleges have recently published an informative handbook entitled "Medicine as a Career" which elaborates on some of these considerations. Ward Darley, M.D., former dean of the School of Medicine at the University of Colorado, now head of the Association of American Medical Colleges, in discussing the present needs and critical years ahead, has said, "The crisis we are approaching is the most serious that medical education has faced since the Flexner Report." The Flexner Report in 1910 was the culmination of the campaign by the American Medical Association to put the medical diploma-mills out of business. This points up the grim significance of Dr. Darley's statement.

The members of the Medical and Chirurgical Faculty of the State of Maryland, are expected to do whatever they can at the local and state levels to

THURSDAY, SEPTEMBER 15, 1960

Thurs

floo

The Maryland Obstetrical and Gynecological Society

will hold a cocktail party and dinner meeting at the Beach Plaza in Ocean City. TIME: 6:30 P.M. SPEAKER: Colonel H. C. Riva, M.C., Chief of Obstetrical and Gynecological Service, Walter Reed Hospital. TOPIC: Experience with Vaginal Delivery Following Previous Cesarean Section.

attract eligible students into medicine and its allied fields, such as nursing and medical technology. The House of Delegates unanimously passed a resolution on September 18, 1959 providing for such recruitment by its members and the establishment of a subcommittee of the Committee on Public Instruction to give this effort proper direction. This Subcommittee on Medical Careers should become effective in a few months. You are urged to give it your support.

Whitmer B. Firm

Whitmer B. Firor, M.D., President
The Medical and Chirurgical Faculty of Maryland

OCEAN CITY MEETING

PROGRAM (continued)

MEDICAL AND CHIRURGICAL FACULTY FRIDAY, SEPTEMBER 16, 1960

REGISTRATION-9:00 A.M.-Lobby

All members and their guests are requested to register. Those who arrive on Thursday, September 15, may register that evening from 7:30 to 9:30 P.M.

BUSINESS SESSIONS

COUNCIL MEETING Thursday, September 15, 2:30 P.M. Beach Lounge, Ground Floor

HOUSE OF DELEGATES Thursday, September 15, 8:00 P.M. Friday, September 16, 9:30 A.M.

All members of the Faculty are invited to attend the meetings of the House of Delegates, but privileges of the floor are for delegates only.



LUNCHEON

Your choice of

SMORGASBORD — 1:30 — 3:30 P.M.

Dining Room

Menu will include lobster, imperial crab, baked ham, fried chicken, salads, and dessert.

CLAM BAKE - 2:00 - 3:00 P.M.

On the Beach

Menu will include lobster and clams from the pit, steamed crabs, corn on cob, fried chicken, salads, and dessert.

Dress obtional for either luncheon

DANCE

9:30 P.M.-1:00 A.M. - Dining Room

Hors d'oeuvres will be served

Host — Medical and Chirurgical Faculty

Dress optional

Arrangements Committee

Committee on Scientific Work and Arrangements: William E. Grose, M.D., Chairman; Houston S. Everett, M.D.; J. Douglas Lockard, M.D.; Joseph B. Workman, M.D.; William Carl Ebeling, M.D.

WOMAN'S AUXILIARY

Medical and Chirurgical Faculty

Mrs. William S. Stone, President Social Room, Main Floor

Friday, September 16

9:30 A.M. Open Board Meeting Social Hour to follow

The wives of all doctors present for the Semiannual Meeting are invited to attend this meeting.

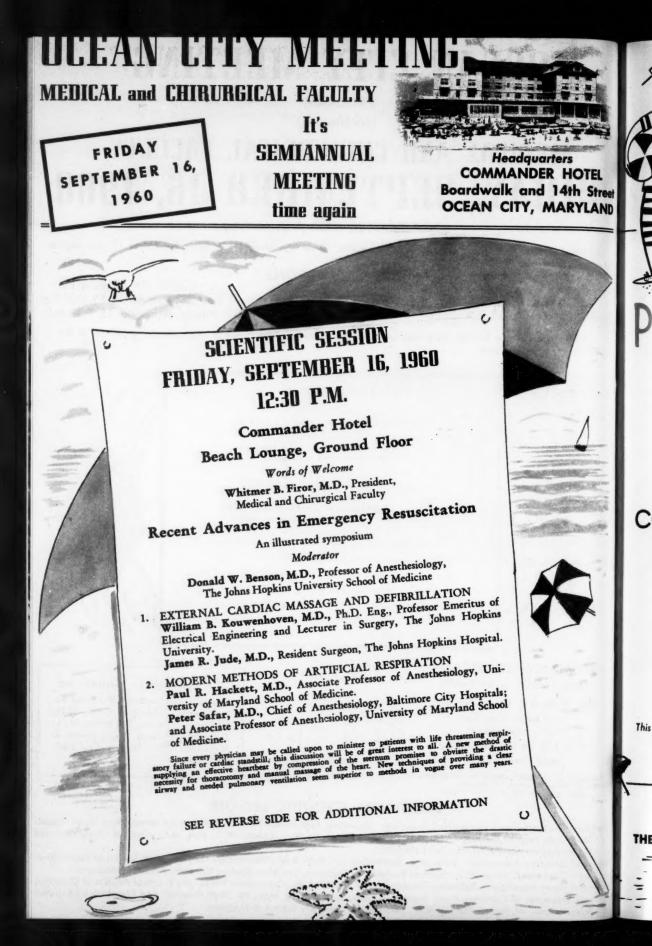
Coffee and Buns will be served informally

ADDITIONAL SCIENTIFIC SESSIONS

Maryland Obstetrical and Gynecological Society. Thursday, September 15, 6:30 P.M., at the Beach Plaza Hotel. Experience with Vaginal Delivery Following Previous Cesarean Section—Colonel H. L. Riva, M.C., Chief of Obstetrical and Gynecological Service, Walter Reed Hospital.

Maryland Diabetes Association. Saturday, September 17, 9:00 A.M., Commander Hotel. Clinical Studies of Insulin Binding—Thaddeus E. Prout, M.D., Assistant Professor of Medicine, The Johns Hopkins University School of Medicine.

Maryland Heart Association. Saturday, September 17, 10:00 A.M., Commander Hotel. The Practical Aspects of Diagnosis and Treatment of Coronary Heart Disease—Charles K. Friedberg, M.D., Mt. Sinai Hospital; and Diagnosis by Cardiac Auscultation—W. Proctor Harvey, M.D., Georgetown University School of Medicine.





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JOIN YOUR FRIENDS AT THE

POSTGRADUATE SESSION IN HEART DISEASE

OF ESPECIAL INTEREST TO THE PRACTICING PHYSICIAN

OCEAN CITY

MARYLAND

SEPTEMBER 17 9:00-12:00 noon

This is the morning following the semi-annual meeting of the Medical and Chirurgical Faculty at the same hotel.

presented by

THE HEART ASSOCIATION OF MARYLAND

and

THE MARYLAND HEART CHAPTERS



John Sargeant Executive Secretary YOUR

MEDICAL

FACULTY

AT WORK

The Executive Committee and Council of the Faculty met at various times and took the following actions:

Executive
Committee,
April 26, 1960

1. Approved submission of a revised Veterans Administration Fee Schedule for

the VA Home Town Care program.

- 2. Adopted policies and procedures for guidance of the Executive Committee and staff members.
- 3. Handled other routine matters referred to it.

Committee, May 24, 1960 1. Heard details of a proposed Blue Cross/ Blue Shield joint policy from representa-

tives of both Blue Cross and Blue Shield boards.

- Authorized a change in the Civil Defense emergency telephone system so that a land line would be installed to the Department of Traffic Transit.
- 3. Requested the Civil Defense chairman to endeavor to obtain reimbursement for civil defense costs that have been paid by the Faculty.
 - 4. Selected Robert W. Johnson, Jr., M.D., of Baltimore, as the Faculty's candidate for the Governor's Award on Employment of the Physically Handicapped.
- 5. Authorized the legislative chairman to prepare the model antiquack law for presentation to the Legislative Council in 1960.

6. Authorized hiring a parliamentarian for the Semiannual Meeting.

Executive Committee, June 7, 1960 Heard a general discussion from various individuals who are opposed to the joint

Blue Cross/Blue Shield policy.

and Council, June 28, 1960 Executive Committee 1. Authorized Medical Society sponsorship of the film, "Drug Addiction—A Medi-

cal Hazard," at the Fourteenth General Assembly of the World Medical Association, at the request of the Universty of Maryland, Department of Pharmacology.

- 2. Approved in principle the proposal that would require revocation of a physician's license if he is a narcotic addict and suspension of revocation, during which period he would not be permitted to prescribe narcotics. Referred this proposal to the Board of Medical Examiners.
- 3. Approved of liaison with the Maryland Chapter, American Physical Therapy Association.
 - 4. Approved offering to component societies the services of the Faculty in billing for annual dues, if components wish such service, and authorized the inclusion

of AMA dues with Faculty and Component bills.

- 5. Authorized attendance of designated individuals at a legislative meeting in Hershey, Pennsylvania, August 26 and 27.
 - 6. Heard a report from the AMA that Internal Revenue Department rulings permit deduction of assessments by members when computing net taxable income.
- 7. Appointed Howard B. Mays, M.D., assistant treasurer of the Faculty.
 - 8. Changed business sessions at the Semiannual Meeting to the following:
 - 2:30 p.m., Thursday, September 15, Council
 - 8:00 p.m., Thursday, September 15, House of Delegates
 - 9:30 a.m., Friday, September 16, House of Delegates
 - 9. Authorized expenditure of up to \$1,000 for

an educational program on aging, as requested by the Faculty's Committee on Aging.

- 10. Referred a statement from the Maryland Hospital Service, Inc. (Blue Cross) to the House of Delegates for its information and any action it wishes to take. The statement refers to transfer of radiology and pathology benefits from Blue Cross to Blue Shield.
- 11. Authorized issuance of debentures to Faculty members, if such is legal and feasible; funds to be used for building purposes rather than raising a mortgage.
 - 12. Instructed the secretary and the executive secretary to prepare a summary of actions and activity in connection with Blue Cross and Blue Shield matters for the information of the House of Delegates members.
- Expressed appreciation and thanks to the arbitrators in the Cambridge, Maryland, Hospital dispute.

ETHICS CORNER

In the recently revised Principles of Medical Ethics of the A.M.A., to which all members must subscribe by virtue of the Faculty's Bylaws, one section is quoted below:

Section 5. A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

The first part of this section deals with a problem many physicians are faced with during the course of practice: What is the best manner in which to advise a patient that the physician no longer wishes to serve him? This question has been posed many times. While no pat answer can be given, since each situation varies with the circumstances, it would appear generally that the best manner in which to do this is in the form of a personal letter.

The patient should be advised that the physician no longer wishes to take care of him, and the physician should establish a cut-off date for rendering care and offer to the patient the service of providing a summary of the records held to a new physician of the patient's choice. A carbon copy of the letter should be retained by the physician for future reference and for his protection should the need arise.

There is nothing mysterious or difficult about advising a patient of this action. It must, however, be handled with tact and understanding to avoid angering the patient.

It is a great honor to be invited to address a medical society whose very name indicates its long and honorable lineage. I am grateful for the privilege. It is a still greater honor to be invited to deliver the 1960 J. M. T. Finney Fund Lecture, and for that honor I am even more grateful.

GENERAL FINNEY AND THE U. S. ARMY MEDICAL SERVICE

Because Dr. Finney was an illustrious surgeon, one's first instinct, in planning the Finney Lecture is, naturally, to speak on some surgical subject. I have preferred, however, to take my point of departure from his Army service and to discuss with you progress in Army medicine, a subject in which I am sure Brigadier General John M. T. Finney, MC, Reserve, would have had a great and continuing interest. I wonder what he would say in 1960—18 years after his death, more than 40 years after his own brilliant Army service—about what we are doing today and what we have accomplished in the recent past. I hope and believe that he would approve.

Dr. Finney, as you no doubt know, was born in Natchez, in the deep South, in 1863. In her travail, as he relates in his autobiography, his mother must have heard the sound of gunfire; for there was fighting within earshot of the house. Perhaps his subconscious awareness of the suffering endured by men of good will on both sides of that terrible conflict influenced John Finney to become a physician. At any rate, he entered the Harvard Medical School immediately after his graduation from Princeton. From his earliest recollection his one idea had been to study medicine. Nothing else ever interested him.

After an internship at Massachusetts General Hospital, he returned to Baltimore in 1889, to the newly opened Johns Hopkins Hospital and to the beginning of a brilliant medical career. It almost ended in 1912, when he was offered the presidency of Princeton University, his own alma mater and that of his forebears, in succession to Woodrow Wilson. His refusal, he wrote later, was "the most difficult and important decision" of his whole life. Had he accepted, he could not have become the first president of the American College of Surgeons the following year, nor could he have rendered to Army medicine in World War I the distinguished services upon which I am building this talk.

In 1908, after earlier service in the Medical Corps of the Maryland State Militia, Dr. Finney was commissioned a first lieutenant in the Army Medical Corps Reserve. As a major, he took Base Hospital No. 18, the Hopkins unit, to France in June 1917. Six months later he was appointed chief consultant in surgery of the A.E.F. He was still a major. He did not become a colonel until June 1918 nor a brigadier general until October 1, 1918.

In the role of chief surgical consultant for the A.E.F., General Finney found himself with executive as well as clinical duties. Since his department supervised the surgical work of the entire theater, he had to devise some method of dividing his responsibility. He accomplished this by assigning competent surgeons, who reported directly to Headquarters, to direct the surgical work within given sectors extending from the front lines back to the base hospitals. It was an admirable solution of his difficulties.

The citation that accompanied General Finney's Distinguished Service Medal calls attention to two of his most valuable contributions to Army medicine. It read:

He rendered distinguished services in the organization of Surgical Teams, for the purpose of affording surgical aid to the wounded in the immediate vicinity of the battlefield. He has done much to standardize the practice of surgery in war, and giving so freely of his professional experience and skill, he has in many ways rendered services of exceptional value to the Government.

PROGRESS in

MEDICAL PROGRESS IN WORLD WAR II

THERE SEEMS to have been no real beginning, nor will there ever be an ending, to progress in Army medicine. World War I, perhaps for the first time, brought a real appreciation of the requirements of a well organized and completely coordinated medical service. Such a service is a complex organization with many components, including, among others, administration, training,

The surgical teams General Finney conceived and set up in World War I were expanded, in World War II, into the Auxiliary Surgical Groups whose teams, working far forward, saved innumerable lives by their competent, selfless service. The standardization of surgical techniques which he began in World War I and upon which the care of the wounded must necessarily be based also came to full fruition in World War II.

In a letter to his wife, written from France January 27, just after he had assumed his consultant duties, General Finney wrote:

One of the things that I am most anxious for in my work in connection with the surgery of the War, so far at the A.E.F. is concerned, is that after it is all over it can be truthfully said that in addition to giving our soldiers the best possible care and attention, we have also added something to our present knowledge and skill in the diagnosis and treatment of military surgery in its broadest sense. It is not enough simply to do as well as the English and French are doing now, good though that is; we must by a scientific study of conditions add something to the sum total of human knowledge in this respect.

General Finney did achieve the results he desired, and he later served actively on the editorial board of the history of the U. S. Army Medical Department in the First World War, in which that knowledge is perpetuated.

During the war General Finney also played a role

in the appointment of one of my most distinguished predecessors, Major General Merritte W. Ireland. In 1918, when Surgeon General Gorgas was approaching retirement, General Pershing sent General Finney to Washington with a personal message to President Wilson. The President and General Finney had been friends since their Princeton days. The message was that General Pershing, the Medical Department, and the entire A.E.F. desired General Ireland as the next Surgeon General and had "no second choice." The message was duly delivered to the President, as from one Princeton man to another. The President arranged an appointment for General Finney with Secretary of War Newton D. Baker, who promised to do his best to secure General Ireland's appointment. Because circumstances would prevent their meeting personally again, it was arranged that when General Finney received a message that he need no longer remain in Washington, he would know that his mission had been accomplished. Two days later he received it, and he was on the high seas, on his way back to Europe, when he was informed officially that General Ireland was to be the next Surgeon General.

Dr. Finney was to receive still other recognitions of his Army service. In June 1943, just a year after his death, the War Department, in line with its policy of honoring members of the Medical Corps who had rendered outstanding service, gave his name to the Army hospital just completed at Thomasville, Georgia. Earlier, on his seventy-fifth birthday, he had received a personal letter from President Franklin D. Roosevelt, expressing appreciation of his many years of work for the American Red Cross and also referring to his service to the Army in World War I.

ARMY MEDICINE

hospital construction and management, and professional specialization. Without the proper operation of all these activities, a comprehensive and adequate medicomilitary service is not possible.

Progress in the implementation of this concept may have seemed slow after World War I, but progress there was. The development and training of reserve units during this period and the continuation of professional training made it possible for the Army Medical Department to meet the demands of mobilization in 1940 and to expand with the expansion of the whole Army in 1941 and throughout the war. Progress reached its peak when the Army strength rose to about eight million men, twice the number of World War I, and active fighting occurred in widely scattered areas all over the world.

Presented at the One Hundred Sixty-second Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland on April 21, 1960.

*The Surgeon General, Department of the Army.

The lessons learned—and relearned from World War I—during the four-year period of United States participation in the Second World War are well known to this audience. You may also read them in the Medical Department history, the fifteenth volume of which has just appeared. Certain of these developments warrant brief comment.

Administrative considerations

Administratively, a consultant system was set up early in World War II, patterned after the concept General Finney had established in World War I. As the war progressed, the consultant system became wider in scope and of ever increasing effectiveness. It played a stellar role in ensuring medical care of the highest quality for troops in all parts of the world.

Surgical advances

In World War II the surgery of trauma reached a height of excellence never before achieved. The sulfonamides, and penicillin after it became available, played an important part in these results; but it was the understanding application of the principles of thorough debridement and delayed primary wound closure—both developed, it should be remembered, in World War I—that conquered the greatest deterrent to successful traumatic surgery; that is, wound infection.

The World War II advances in surgery included the recognition that initial wound surgery is itself both a part and an objective of resuscitation; improvements in the concept and management of shock, including the liberal use of whole blood, for which it was soon learned there could be no substitute; studies on the physiologic effects of wounds, including the prevention of lower nephron nephrosis; the management of wet lung; the development of decortication; removal of foreign bodies from the chest, heart, and great vessels; numerous advances in peripheral nerve surgery; the development of a new and compassionate concept of paraplegic management and its successful implementation; the rapid air evacuation of seriously wounded casualties to specialized treatment centers; and the establishment of these centers. To these tangible factors, all of which contributed so greatly to the outstanding results of traumatic surgery in World War II, must be added an intangible factor, which was not the least of them, the dogged determination of the most competent men in American medicine to provide the best possible care for the wounded. The results speak for themselves. In World War I, about 6.1 per cent of the wounded died of their wounds. In World War II, only about 4.5 per cent were lost.

Medical advances

In World War II, there were important advances in the medical management of numerous diseases, the most spectacular being secured by the use of the new drugs. The morbidity and mortality of the venereal infections, lobar pneumonia, meningitis, streptococcic infections, and the dysenteries fell sharply when the sulfonamides and, later, penicillin were employed.

Neuropsychiatric advances

Neuropsychiatry was first recognized as a medicomilitary specialty in World War I, but its widest application came in World War II, in which psychiatric disorders proved the greatest single cause of disability. As a result, a new concept of preventive psychiatry was developed and fostered, based on the fundamental principle of early treatment in forward areas, a method which proved as practical and as effective as it was obviously necessary. Neuropsychiatry was to prove of even greater value in the Korean War than it had been in World War II.

Advances in preventive medicine

In World War I, deaths from disease were about the same numerically as deaths from combatincurred wounds and injuries. The ratio was 1.02:1. In World War II, the ratio was 1:14. This remarkable alteration and the resultant saving in human life and in manpower can be attributed in large part to improvements in the control and treatment of the infectious diseases. Both the number of cases and the deaths from these conditions were many times fewer proportionately in World War II, in which 75 per cent of all deaths were due to battle injuries, 20 per cent to non-battle injuries, and only 5 per cent to disease.

In World War II there was, for the first time,

an awareness of the true worth of scientific preventive medicine and its procedures and practices. The challenges presented were world-wide. Both familiar and unfamiliar diseases were encountered, and familiar diseases in a new environment often assumed new guises. The approach to control had to be many-sided: immunological, chemical, environmental, and hygienic.

Immunization techniques were brilliantly successful. They included, as they still do, protection against typhus, cholera, yellow fever, plague, induenza, and tetanus. Tetanus immunization was first proposed by the Medical Department in the spring of 1940. It was finally authorized in June 1941, just six months before Pearl Harbor. As General Finney noted in his autobiography, this disease was rife in the early days of World War I, and it remained a potential threat to the end of the war. In World War II it was never a threat. As the result of routine immunization of all troops, there were only 12 cases of tetanus recorded during the war, and in only four of these had the complete routine of immunization and booster injections been carried out. Six men had not been immunized at all. The five deaths in these 12 cases need no comment. The attack rate per 100,000 wounded and injured in World War II was 0.44. compared with 2.4 for the period between the World Wars and 13.4 in World War I.

In the areas of personal and environmental control of disease, a major new concept of World War II was the application of insecticides and repellants with long-lasting or residual effects. As a result, for the first time in history, body lice, the vectors of epidemic typhus, were controlled by a long-lasting chemical, DDT, and the cumbersome, unpleasant, and not very effective steam disinfestation technique of World War I could be abandoned. New principles and concepts were also applied in other areas of sanitation and environmental modification, to the enormous benefit of all soldiers.

PROGRESS IN THE KOREAN WAR

In the interim between World War II and the Korean War, there was a considerable reappraisal of the Army Medical Department and a consequent rehabilitation. The professional consultant system was continued in operation and has proved of inestimable aid over the succeeding years.

Also notable in the period between World War II and the Korean War were the programs which provided refresher professional training for career medical officers and residency training in the specialities for young officers just entering upon their Army service. The justification for these programs became fully apparent in late June 1950, when the North Koreans crossed the 38th Parallel and U. S. Army forces had to be sent to Korea. The medical situation was extremely grave, for the Army Medical Service had been functioning with only about 50 per cent of its authorized medical officer strength.

It was at this juncture that the refresher courses and the residency programs just described indeed paid off. Many of the officers who had taken them and who were then taking them were rushed to the Far East. Here their competence, skill, and fortitude accomplished such wonders that the percentage of the wounded who subsequently died of their wounds fell from the 4.5 per cent of World War II to about 2 per cent. In the military hospitals in Pusan, Taegu, Yong Dong Po and other locations, these young men, many of them interrupted in the midst of their training, performed like veterans even as they were becoming veterans. They accomplished feats of traumatic surgery on severely wounded casualties well beyond what might have been expected or hoped for from surgeons with far more training and experience.

These refresher courses and training programs are still in effect. Progress in Army medicine can be evaluated most significantly by the development in professional stature of the officers in the service. One evidence of this increase is the fact that among the 1,734 Regular Army officers on duty at the beginning of 1960, 524 (30 per cent) were certified by one or another of the medical specialty boards.

Preventive medicine

The medical successes of Korea, of course, were not confined to the battalion aid stations and the surgical wards. U. S. Army troops there, in addition to the hazards of combat against a vicious foe, were faced with environmental medical problems. In summer, these included heat exhaustion, malaria, dysentery, and Japanese B encephalitis. In winter, louse-borne typhus and cold trauma had to be contended with. Later in the war, hemorrhagic fever appeared.

Typhus, though frequent in the native Korean population, did not occur at all in the U. S. Armed Forces. This is quite remarkable, for the lice that infested both North Korean and Chinese prisoners were found to be resistant to DDT, and it was necessary to develop new insecticides to control them. Also, the dysenteries encountered at the prison compound of Koje-do did not respond at all to the sulfonamides but only to the broad spectrum antibiotics. The lessons learned in these two diseases have been valuable in peacetime and will be invaluable should another war come.

Perhaps no other disease ever encountered during combat has received such intensive study in as short a period of time as hemorrhagic fever received during the Korean War. Although the cause remains to be identified, the death rate during the war was progressively reduced from about 16 per cent in the first cases to less than 4 per cent in the last. Equally important, careful epidemiologic investigations showed that the disease could be prevented in large measure by reducing the brush cover for rodents and their parasitic mites.

RESEARCH IN THE ARMY MEDICAL SERVICE

One of the important challenges facing the Army Medical Service is its mission to improve the art of military medicine. This is accomplished in two ways. The first is by exploiting every new situation and experience for the betterment of the service. The second is by directing long-range research efforts to the potential medical problems associated with new and often untried weapons systems of the future.

More than 40 years have elapsed since the end of the war in which General Finney did so much to advance the science and art of military medicine. In the interim, we have fought two wars; and other events and situations have resulted in the acquisition of new knowledge and new techniques in the Army Medical Service. Organized research and development activities, unknown in the Medical Department of 1917, have now become one of the major functions of the Medical Service. In Army medicine, just as in civilian medicine, provision for research permits an attack on current problems and accelerates medical progress by basic medical research.

In the face of wartime necessities, medical of-

ficers have perfected techniques of amputation and of blood vessel grafting and transplantation, have improved prosthetic devices, and have made innumerable other surgical advances. Many of these and similar studies could be carried out only close to the battle line. During the Korean War, therefore, research teams were dispatched to forward areas to study shock, resuscitation, battle trauma, vascular injuries, acute renal failure, body armor, and causes of death after wounding. These investigations, the magnitude of which is physically evident in the four large volumes in which they are reported, were built upon and carried forward the knowledge accumulated in the similar but less intensive studies begun in World War II.

Two diseases might be mentioned in which the results of research have been especially outstanding. The first is malaria, which accounted for an appalling loss of man days in the early fighting in World War II, both in the Pacific and in the North African Theatre. When our source of quinine was threatened, renewed and more energetic attempts were made to develop chemical compounds that would repress acute attacks and would also cure this ancient scourge of mankind. These objectives were accomplished by the combined efforts of civilian and military investigators too numerous to name, who demonstrated the safety and effectiveness of chloroquine as a suppressive agent and later of primaguine as a curative agent for vivax malaria This remarkable example of collaborative research supplemented the Army's longstanding program for malaria and mosquito control.

From World War I onward, tuberculosis was the cause of a tremendous loss of manpower to the Army and of enormous expense to the country in terms of disability pensions and hospital care. In World War II, careful screening before induction greatly reduced the manpower losses from this cause, but treatment was never satisfactory. The relapse rate after any therapeutic method was so high that it was not practical to return these men to military duty. All patients with active disease were, therefore, permanently separated or retired from service.

Over the past 10 years this situation has completely altered. With the introduction of specific drug therapy and the development of new surgical techniques, it has become possible to treat successfully and return to active duty more than 90 per cent of well trained, career-motivated soldiers,

either immediately after treatment or after temporary retirement. In more than 3,000 military patients treated in this manner the relapse rate has been less than 4 per cent, and the saving to the Government is running more than a million dollars annually.

Investigations now under way in various fields cover shock, burns, cold injuries, many special diseases, and special environmental hazards, current or potential, including a search for anti-radiation drugs. We are working on a new evaluation of the topical treatment of wounds with antibiotics and on the evaluation of wound ballistics, as a result of studies with the more "exotic" missiles. We are also devoting serious efforts to defining the timely treatment of casualties from chemical warfare agents.

To provide a means for the study of diseases not usually encountered in the United States, the Army Medical Service maintains small research laboratories in Puerto Rico, Malaya, and Japan. The Navy has similar laboratories in Egypt and Formosa. These two services exchange information, and each provides laboratory space for investigators from its fellow service.

The information gained from these and other research studies is not used only in the Armed Forces but is also made available to the entire medical profession.

THE PROBLEMS OF THE FUTURE

As we survey the problems of today and approach those of tomorrow, many of which are as important to the civilian community as to the Armed Forces, it becomes more and more evident that one of our chief concerns is the protection of the soldier from the adverse effects of natural and induced environmental conditions. Man is the ultimate weapon. We must make sure that he is never subordinated to a system or to his environment. We have learned from both the Second World War and from the Korean War that battle casualties account for some 20 to 25 per cent of admissions to medical facilities. The remaining 75 to 80 per cent are for non-battle conditions, many of which arise directly from the adverse effects of environment. It is a safe, though unhappy, prediction that future wars, wherever they may be fought, will bring with them similar medical problems and resultant losses of manpower from the effects of unfavorable environment. We must prevent those losses by solving those problems.

Added to the environmental hazards with which we have some familiarity from past experiences are the hazards created by new and modern military techniques and ultrasophisticated weapons systems. These new hazards arise from many sources, including the utilization of new physical, chemical, and biologic agents, as well as from radiologic energy, both of the ionizing and the microwave varieties.

One obvious necessity of present-day research is the development of methods to determine the amount of radiation a casualty has received. We must also find out how to treat casualties who have been exposed to excessive doses of radiation. In line with these necessities, the Walter Reed Army Institute of Research is currently engaged in a population survey to detect and monitor the human whole body content of several gamma radio-nuclides. One of these substances, cesium-137, is solely the result of fallout from nuclear weapons tests. Other related studies deal with the identification and metabolic fate of various gamma radionuclides in the living human, in animals, in biologic specimens, and in certain other substances, such as foodstuffs.

This mission is being accomplished by the utilization of special instruments not available anywhere else in the United States. The equipment is cumbersome and the work is tedious and time-consuming, but the importance of this knowledge to both civilian and military medicine fully justifies the investment in money, time, and personnel.

THE CHALLENGE OF THE FUTURE

Our present and future tasks, then, lie in the protection of our troops from conditions, substances, and techniques incidental to our own offensive and defensive efforts, as well as from those resulting from the offensive efforts of our enemies. The Army Medical Service is continuously faced with the requirements of new conditions and new situations. We must develop and apply to them new concepts, techniques, and practices in military medicine. And we must hope and pray that we shall be given the wisdom and the judgment to overcome the problems which face us and to continue the progress which has become the tradition of the Army Medical Service. The same spirit that

has carried us through all previous wars will, I am sure, help us and sustain us as we attempt to rise to the terrible challenges of this era of uneasy peace.

Again I wish to thank the Medical and Chirurgical Faculty of the State of Maryland for the pleasure and honor of presenting the 1960 John M. T. Finney Fund Lecture. In conclusion, let me say something more of the distinguished surgeon whom this lecture honors. Dr. Finney's whole professional life, in addititon to his notable accomplishments in surgery and in Army medicine, has left us with a better understanding and a broader appreciation of the total responsibilities of the physician, of the fact that a physician's greatness depends not alone upon his skill but also upon his heart and upon his sense of responsibility to the community of which he is a part.

In paying tribute to this most renowned American surgeon and this Christian gentleman, we are reminded once again of the close kinship between civilian and military medicine and of the type of leadership we must develop in both to preserve our national heritage in this uncertain world. That leadership Dr. Finney provided in his life. I like to think that he might have thought, as I do, that both the civilian and the military medical profession might be stirred, and would respond, to the ringing call to action which Tennyson has Ulysses utter at the end of that splendid poem:

. . . Come, my friends.

'Tis not too late to seek a newer world. Push off, and sitting well in order smite The sounding furrows; for my purpose holds

To sail beyond the sunset, and the baths Of all the western stars, until I die.

Department of the Army Washington 25, D. C.

SCIENTIFIC PAPER

UROLOGY AWARD

The American Urological Association offers an annual award of \$1000 (first prize of \$500, second prize \$300, and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than ten years and to hospital internes and residents doing research work in urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Biltmore, Los Angeles, California, May 22-25, 1961.

For full particulars write the executive secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1960.

BOWEL REHABILITATION in the constipation of pregnancy

Michael B. Monias, M.D.
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ONSTIPATION, which occurs in an estimated 40-50 per cent of all patients, is undoubtedly the gastrointestinal complaint most commonly encountered in the general practice of medicine. In pregnancy, with the problem of organ displacement caused by the growing fetal pressure on the colon and with general hormonal changes, the incidence of constipation is considerably greater. Relief during the prenatal period and re-education of the bowel muscles during the postpartum period is a problem faced by every obstetrician.

Because of the inherent dangers in the usual cathartics (1-3), a study was made to evaluate a standardized senna derivative* which acts on the neural elements of the large bowel (the myenteric plexus), rather than on the bowel mucosa. When bowel re-education becomes necessary in the postpartum state, this type of constipation corrective could be of inestimable value.

Senna derivatives are broken down into active glycoside components by the enzymatic action of normal lower intestinal flora. They do not affect the large bowel of the fetus, nor do they have any lactation effect, since the fetal gastro-intestinal tract remains sterile during the first six months after birth.

MATERIAL AND METHODS

The number of patients in the study was 151; 43 were primiparae and 108 were multiparae. All were between 10 and 36 weeks of gestation and complained of constipation of at least four weeks' duration.

All patients were seen at four-week intervals up to 32 weeks of gestation and thereafter at one week intervals up to the date of delivery. After

Relief from constipation during the prenatal period and re-education of the bowel muscles in the immediate postpartum patient are common problems. A study was initiated to evaluate a standardized senna derivative which acts on the neural elements of the large bowel rather than on the bowel mucosa. Of the 151 patients studied, 108 (71.5 per cent) achieved bowel rehabilitation with a single course of therapy, 23 had good results, 13 had fair results. There were seven failures. The best results were obtained in primiparae. From personal observations it seems likely that if constipation is prevented in the first pregnancy, the tendency toward constipation in subsequent pregnancies will be lessened.

delivery they were seen daily for the first five days, and subsequently in the sixth and twelfth postpartum week. Each patient maintained a written record of bowel function checked at every visit to the prenatal clinic.

For the purpose of this study, constipation was defined as the passage of hard stools less than once a day. A normal state was one in which the stool was of medium consistency and bowel movement took place once or twice a day.

A preliminary study of 25 prenatal patients determined the most effective dosage to be one tea-

^{*}Senokot®, The Purdue Frederick Company, New York, N. Y.

TABLE I

	Excellent	Good	Fair	Poor	
Primipara	40	2	0	1	
Multipara	68	21	13	6	
Total	108	23	13	7	
Per cent	86.7	7%	8.6%	4.7%	

spoonful of the standardized senna granules at breakfast and dinner for three days, one teaspoonful a day for another three days, then one teaspoonful every second day for two weeks. A maintenance dose of one teaspoonful twice weekly was used after this.

RESULTS

Response to the drug was divided into four broad categories. An excellent response was one in which there was not only restoration of normal bowel function but in which normal function persisted even after the drug was discontinued. A good response was one in which a continuing dosage of one teaspoonful twice a week was necessary to maintain normal bowel function. A fair response required a maintenance dosage of one teaspoonful every second day after restoration of normal bowel function. A poor response was one in which there was no restoration of normal bowel function on the dosage used.

Of the 151 patients in the study, 108 were rated excellent in their response to the medication; of these 40 were primiparae and 68 were multiparae. Twenty-three patients, of whom two were primiparae and 21 multiparae, had good results. Thirteen patients, all multiparae; had fair results, and there were seven failures, one primipara and six multiparae.

DISCUSSION

Constipation occurring in the latter trimesters of pregnancy and during the immediate post-partum state is, in all probability, a function of two generalized body changes: one, the loss, to some extent, of muscle tonus throughout the body (4); the other, the displacement of visceral organs by the gravid uterus.

The loss of muscle tonus, especially in the muscularis of the colon, is a physiological function of late pregnancy, possibly in preparation for the actual dynamics of parturition.

As the gravid uterus expands and grows, the colon is moved upward to curve around the uterine fundus, and the cecum is crowded up and outward. The initial displacement and crowding of these organs, as well as their readjustment in the immediate postpartum state, is largely responsible for the almost universal complaint of constipation during this time. In the puerperant, the condition is partially aggravated by the widespread use of analgesic drugs in labor and the use of narcotics for relief of after-pains.

This total complex results in an obstinate and often intractable constipation. Its dangerous sequelae (abrasions and fissures of the rectal mucosa, internal and external hemorrhoids, prolapse of the rectal mucosa, and pyelitis) hardly need to be elaborated. The routine uses of cathartics, enemas, and even harsh purgatives in the latter trimesters of pregnancy are outgrowths of this complex. The need, however, is less for the palliative results of an immediate control than for the long term rehabilitation of the bowel. The senna derivatives employed in this study, by acting upon the neuroperistaltic components of the bowel, avoid the usual mucosal irritation of laxatives and actually seem to have a reconditioning effect on the defecation process. Proof of this would seem to lie in the fact that 108 patients, 71.5 per cent of the number studied, achieved bowel rehabilitation with a single course of therapy. Although we must consider that some of the patients classified as excellent could have had a transient type of constipation, still the resultant rehabilitation, when it actually occurred, is an effect sorely needed by the fatigued muscles of the puerpera.

CONCLUSION

The standardized form of senna provides a safe and physiologically correct method for treating the constipation of pregnancy and rehabilitating the defecatory mechanism of the puerpera.

69 Franklin Street Annapolis, Maryland

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Many of you, I assume, occasionally have to recommend in-patient care for patients who become disturbed emotionally; and, no doubt, you are sometimes troubled by the problem of finding suitable care for the many individuals who cannot afford the high cost of private psychiatric hospitalization. I should like to share with you some of my observations from working in a modern state hospital, the Springfield State Hospital.

WHAT HAPPENS to your patient when he enters a mental hospital? I wonder what you have thought might happen. I ask this because my own thoughts when I referred a patient to a mental hospital used to be rather more gloomy than the situation warranted. At best, I envisioned the

staffed, is a sad prospect. Yet, for many patients who enter Springfield, the situation is considerably different from what I had imagined it to be. To illustrate, I will describe the experience of a 19-year-old, schizophrenic girl who enters with commitment certificates stating that she has be-

IN-PATIENT PSYCHIATRIC CARE in a STATE HOSPITAL

Riva Novey, M.D.

patient hurriedly admitted, along with dozens of others, rushed off to the electric shock machine, then dismissed from the hospital. At worst, I imagined my patient becoming one of the unfortunates who sit dejectedly in crowded halls for indefinite lengths of time, as depicted in newspaper photographs of mental hospitals.

Now, I think we must be realistic and realize at the outset that mental illness is a terribly unhappy condition and that admission to a state hospital, which is inevitably overcrowded and undercome seclusive and suspicious, that she has the delusion that she is going to marry a young man who, in reality, has no interest in her. Further, she is convinced that she is an important part of a large political movement to improve the world.

The patient has been referred by her family physician, who, being familiar with Springfield, phoned ahead and talked with the pre-admission office. Consequently, the social service department, the physician on admission duty for the day, and the nursing department are aware that she is coming. When the patient and her parents arrive, they are received in a large, attractive waiting room which adjoins several smaller interviewing

Presented before the Women's Medical Society, February 19, 1959.

rooms. A social case worker greets them and talks with all three together, getting from them some pertinent data and then giving them information about the hospital: where the patient will live, what she will wear, when she may have visitors, and whatever else they wish to know.

The admission interview is of great importance, because it helps to correct the many misunderstandings in the minds of patients and their relatives. They may believe, for example, that the patient is to be "put away forever," and they are frequently relieved to learn that the hospital is neither willing nor able to keep patients indefinitely. The main objective of the hospital is to help each patient become able to return to the community as quickly as possible. Another important purpose of the admission interview is establishment of a relationship between the patient and the social service department, which is often extremely useful toward the end of the patient's stay.

Next, the patient is introduced to the admitting physician. He is a resident psychiatrist and, usually, a person who is sincerely interested in people with emotional disturbances and desirous of hearing about the patient's difficulty within the limited time at his disposal. He approaches the patient, as any other physician might, by asking, "What is your trouble?" or "How can the hospital help you?" Here any of a number of responses may happen. The patient may pour out her story of confusion, terror, and grief, telling about the delusions and hallucinations and expressing relief at being in the hospital. She may, on the other hand, be furious about being brought to the hospital, deny that there is anything the matter with her, and make impolite statements about her parents, the doctor who sent her, and the admitting physician.

Another reaction one commonly sees is one in which the patient appears completely composed and non-delusional, expressing bewilderment at being brought to the hospital, along with a curious willingness to be admitted. Only certain aspects of her tone of voice, use of words, and other subtle signs of emotional stress betray her psychotic condition. The acute symptoms described on the commitment certificates, in some instances, may never again appear. The reasons for this change are complex, but one important factor is this: if we realize that psychotic symp-

toms may have developed in a life situation which has become too difficult to handle, we can understand how a person removed from the situation may no longer need these symptoms.

The locked doors of a mental hospital keep the patient in; they also keep out the external factors which may have precipitated the illness. Somehow the patient senses this. The patient also senses the understanding of emotional illness and the acceptance and respect for the disturbed individual, which attitudes permeate the atmosphere of a mental hospital. Troubled as she is, abnormally as she may behave, the patient is accepted as a member of the human race. No one is afraid of her. There are no locked doors to the admission room, no guards or attendants to be seen during the admission interview.

After the admitting physician hears enough to make a tentative diagnosis, he phones for an attendant, who comes promptly and introduces herself to the patient. The patient is allowed a few minutes in which to say good-by to her relatives, who, in the meantime, have talked at length with the case worker. The patient then goes to her ward.

Before discussing what goes on in the admitting ward, I'd like to say a word about the general structure of the usual mental hospital. In most mental hospitals are a number of wards or halls which are designed to offer the patient a series of experiences in living, beginning with one in which he has little freedom or responsibility-where the patient, indeed, is often advisedly treated as a small child-and gradually increasing privileges and responsibilities. Just before leaving the hospital the patient lives in an open ward from which he goes and comes as he pleases, goes to work of one sort or another, makes trips to town, and visits his home. This system has been used for the last century and has been found to be the method most conducive to recovery, with the aid of other methods of therapy, such as occupational therapy, drug therapy, electroconvulsive therapy, and psychotherapy. Under this system, men and women have traditionally lived in separate quarters. You may be interested to know that various hospitals in this country are in the process of making revolutionary changes in this system. Inspired by Maxwell Jones' Therapeutic Community in England and other interesting European experiments, there is a trend toward hospitals where, whenever possible, the doors are not locked, where most patients have much more freedom than they are traditionally permitted here, and where both sexes live on the same ward. In some of these hospitals, many patients live in the community during the day and return to the hospital at night. Another variation, being tried in Baltimore at the Henry Phipps Psychiatric Clinic, is a plan whereby the patient spends the day in the hospital and returns to his home at night.

To get back to our patient who has just been admitted to Springfield:—As with most new patients, she will be taken to the admission ward. Any valuables she has will be put away and kept for her until her discharge, and all of her belongings will be examined to be sure that they contain no drugs or instruments which could be used to harm the patient or others. She will have the usual admission nursing care which goes on in any hospital, she will change to comfortable, washable clothing, and will then go to a lounge where she will meet the other patients.

Relatives frequently ask us anxiously, "Won't it make my daughter (son, husband, or wife) worse to mix with mentally ill patients?" Strangely enough, the answer is no. It may interest you to know that emotionally disturbed patients have a wonderful way of extending comfort and sympathy to new arrivals. To many unhappy, frightened new patients, it is reassuring to be placed near others who are also disturbed and, consequently, more frank in expressing thoughts and feelings which most of us usually keep to ourselves. This frequently aids the patient in becoming more clear about the problem that brought her to the hospital. It should also be mentioned that there are, of course, exceptional patients who use symptoms of mental illness as a means of punishing others or dramatizing themselves. In such cases, exposure to the realities of the admission ward may rapidly lead to an amelioration of the symptoms.

To the newly-admitted patient a number of things will happen during that first week. Routine laboratory work and x-rays will be done. As soon as possible, she will be seen by the physician in charge of her ward, who will form his own impression of her condition and prescribe medication for her, if necessary. She will receive a complete physical examination and a mental status

examination from another staff member. Sometime during her first week in the hospital, she will attend a meeting of staff physicians, nurses, psychologists, and social workers, where she will be interviewed in a kindly manner by the clinical director.

As she lives on her ward, the nurses will observe her carefully and make notes on their observations twice daily. Each day these notes will be sent to the director of the admission service, who keeps a watchful eye on the progress of each patient and regularly consults with the ward physicians. In time, the patient may receive further diagnostic tests; for example, an EEG, if indicated, or a complete psychological examination.

The young woman's course on the admission ward may take a variety of turns. She may become acutely disturbed, a course which does not necessarily indicate a poor prognosis. If she becomes disturbed, she may exhibit such behavior as assaultiveness, catatonic withdrawal, or markedly regressive behavior. We do not see as much of this kind of behavior nowadays as we used to. One reason is that people are sent for psychiatric care in earlier stages of their illness than they used to be. Another, and a major reason for the difference, is the use of tranquilizing drugs, which today make acutely disturbed behavior the exception rather than the rule.

After several days or a few weeks, more than likely, it will become apparent that the patient is ready for the next ward. This will be evidenced by less tension, improved capacity for eating and sleeping, fewer delusions and hallucinations, if present, and better emotional control. She will begin to do some useful work, visit the occupational therapy shop and the library, and eventually have the privilege of walking about on the grounds.

After she improves still further, she will be transferred to a convalescent cottage. There are four convalescent cottages at Springfield, each of which is a pleasant, modern two-story building with lounges, game and TV rooms, conference rooms, and small dormitories, as well as single rooms. These cottages are staffed with well-trained psychiatrists and psychologists who give a great deal of individual attention to their patients. While here, the patient may have the opportunity to participate in group therapy, whereby a number of patients get together with a psychiatrist or psychologist to discuss some of

their difficulties in living. Possibly the patient may have individual psychotherapeutic sessions as well during this time, to aid her further in understanding herself. Let us say that this girl has been involved in an abnormally close tie with her parents, who have treated her as a small child and carefully blocked her every move toward growing up and forming relationships with others. She has clung to her parents, being awkward and withdrawn, tending to daydream constantly, and filled with anger which she projects in the belief that people are against her. She also has pent-up yearnings which finally break out in the delusion that the young man loves her. Feeling her own personality-that is, her own inner world, as it were-breaking up, she develops the idea that a new and better world is to be organized. And she may be right! With or without individual psychotherapy, many young people, during their stay in the hospital, gain new insight and reorganize themselves. I know such a young woman who returned to the community, broke off her excessively dependent tie to her parents while remaining on friendly terms with them, worked at a good job for a couple of years, and is now married.

As the patient comes to understand herself better, she looks, acts, and feels better. While living in the convalescent cottage, she is on a full-time work program, doing useful and necessary work; perhaps in the housekeeping department, library, or on the wards of the medical and surgical building. For recreation, she will participate in athletics, trips to Sykesville, and picnics and other entertainments arranged by interested civic groups.

In due time, the physician in charge of the convalescent area will decide that she is ready to leave the hospital. Her case may be surveyed carefully in a staff conference before this decision is made. Perhaps she will make several visits home to be certain that she can be comfortable outside of the hospital. If the visits go well, she will be released as paroled, which means that anytime during the following year she may return to the hospital, if necessary, with few formalities. If things go well, she will be discharged at the end of a year.

What if the patient has no suitable home to which she can return? She may then be assisted by the Foster Care Department, which is part of

the social service offered by the hospital. The Springfield Social Service Department is nationally known for its pioneer work in developing foster care, a plan in which patients are placed in homes and in jobs in towns and farms in nearby counties. Once the patient has made a satisfactory adjustment, she is discharged from Foster Care and from the hospital. The Foster Care plan thus serves as a bridge between the hospital and community living, and it has had remarkable results in reducing the incidence of chronic mental illness.

I want to be careful not to give you too glowing a picture of what may happen to an acutely ill patient admitted to a state hospital. As we all know, there are among these patients some who will require a long and perhaps indefinite period of hospitalization. If it appears that a patient needs long term care, she is transferred to one of a group of cottages known as the "Women's Group," where chronically ill patients are kept. There is an equivalent "Men's Group." In these groups are some new buildings, but many are old and depressing. The patients are kept clean and are well cared for, and morale is good; but there is no doubt that there is overcrowding and not nearly enough individual attention.

A patient's transfer to the "group" does not mean that there is no hope for her. She will be kept under constant observation, and if she shows improvement, she may again return to the convalescent area and strive toward her return to the community. It is tragic that among these patients are many who could be helped to return to the community if enough psychotherapeutic help were available. Unfortunately, there are not enough psychiatrists and psychologists. In addition, our knowledge of how to help many of these patients by psychotherapy is still in an experimental stage.

Many patients leave the mental hospital and never return; others return occasionally for brief periods or for long ones. Of course, there are some who remain for the rest of their lives. These are, for the most part, people with organic brain damage or problems associated with old age and some schizophrenic patients.

The following figures may interest you:

Number of patients in Springfield now . 3,320

Number of patients admitted each year . 1,300

(one-third are 65 and over)

Number discharged each year	1,300
Number dying annually	360
(mostly old-age group)	
Number on admission service	375
Number in Women's Group	1,069
Number in Men's Group	1,112
Number in Epileptic Colony	480
Number in Geriatric Building	69
Number in Foster Care	130
(rapid turnover here)	
Number of physicians	30
Number of psychologists	5
(plus 5 students)	
Number of case workers	20
Number of nurses	
students	35
graduates	25
Number of attendants and licensed prac-	
tical nurses	681
Number of patients on tranquilizers	1,521
Number of patients on electroshock	24
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You may wonder what you can do to insure that your patient receives the best possible care when you send him to a mental hospital. Perhaps the most important thing is carefully to consider whether in-patient psychiatric care is the only means of helping the patient. This is often a difficult decision. Of course, when you encounter a patient who is acutely delusional or hallucinated. or who threatens to harm himself or others, it is evident that the patient must be hospitalized; however, we receive large numbers of people of every age and walk of life who are not so obviously disturbed but who come because they or their relatives or their physician feels that they need psychiatric treatment, which they are sure that they can get in a mental hospital. One should consider carefully whether such a patient might best be helped by out-patient psychiatric treatment before allowing him to disrupt his school or work situation and exposing him to an experience about which there is still, unfortunately, some social stigma.

The patient and relatives frequently press for hospitalization, the patient seeking refuge from a difficult life situation; the relatives hoping for a long period of relief from the presence of one whose behavior may have been stressful or embarrassing for them. If we consider that about 80 per cent of patients admitted to Springfield each year are discharged before the end of the year,

many of them within a few weeks or months of admission, we can see that hospitalization is no long term solution to the problems just mentioned.

Another important source of misunderstanding is the fact that patients, relatives, and sometimes physicians expect individual psychotherapy to be available to the hospitalized patient. Such expectation is highly likely to result in sad disillusionment. In state hospitals, where each resident carries a case load of perhaps 200 patients, it is unlikely that any one patient will receive individual psychotherapy. (Springfield monthly reports: 18 in January, 13 in December, 25 in November.) One must remember, too, that in most psychiatric hospitals, the resident is a young person with limited experience. The psychiatrist on the outside is necessarily much more skilled and experienced. Many people do not realize that the dollars and cents cost of clinic out-patient or private psychotherapy is considerably less than the cost of hospitalization. In terms of human values, a great deal can be saved by early, adequate outpatient diagnosis and treatment, especially if it results in a person's being prevented from becoming psychotic and thus being helped to avoid hospitalization.

If, after a period of out-patient treatment, it becomes clear that the patient still must be hospitalized, nothing has been lost. For example, a seriously disturbed high school girl in the hypomanic phase of a manic depressive illness was referred to me recently. She was an intelligent and responsive person who wanted help. Because she was getting along well in school, where her illness had not been noticed, and because her parents were able to observe her and care for her in a responsible way, I did not insist on immediate hospitalization. Four weeks of out-patient observation and treatment convinced her parents and me that hospitalization was necessary. Upon being told of this, the patient at first protested, but then asked to make her own arrangements for admission to a mental hospital. This kind of approach to hospitalization offers the patient a much better prognosis than she would otherwise have. In general, securing psychiatric consultation before sending a patient to a mental hospital is usually wise. Once you have decided that hospitalization is in order, it is best to tell the patient frankly that you feel he needs it, even if the patient has not indicated any willingness to be hospitalized. Patients often have a surprising capacity to hear your opinion, and they are frequently relieved by it.

I must inject a special word of caution about the danger of sending adolescents with psychoneuroses or personality disorders to state hospitals, unless the hospitals have special facilities for such treatment. At Springfield, adolescents must live on wards with psychotic patients, which can be a detrimental experience for a non-psychotic youngster.

To briefly review the procedure for arranging the admission of a patient to a state hospital, if a patient requests admission to a mental hospital and seems capable of remaining there voluntarily, a Voluntary Treatment Agreement is signed by one physician. If the patient needing hospital care does not realize that he needs it or seems too disturbed to remain in the hospital voluntarily, two physicians sign commitment papers. To sign commitment papers, the physician must have been licensed to practice in Maryland for at least five years. He does not need to make a psychiatric diagnosis in order to sign the papers, but need only to describe the patient's symptoms and their onset and to state the patient's physical condition. Of course, any other pertinent data he can supply about the psychiatric illness is always immensely appreciated by the hospital staff.

Whether the admission is to be voluntary or by commitment, the patient and/or his relatives are instructed to go either to the State Aid Office at the Department of Public Welfare in Baltimore or to the County Commissioners' Office in their county. It is extremely important that this be done, for the hospital will not accept a voluntary patient who has not already made his financial arrangements. The cost of hospitalization is \$116.00 per month; someone must pay it. If the committed patient comes without his admittance permit, he will not be turned away, but the situation then becomes much more complicated for the family and for the hospital.

The physician, then, should be sure to instruct the patient or relatives to go to the Department of Welfare. He should, in addition, have them phone the hospital's pre-admission office to make arrangements for arriving at a convenient time. By so doing, they will receive much better service. If their arrival is unexpected, they may have to wait for some time; otherwise, they are rarely kept waiting. If they arrive in the middle of the night, the social service I have described may not be available, and they may have a necessarily brief and unsatisfactory contact with the physician on night duty. Relatively few emergency situations arise in psychiatry; so, if a panicky patient or relative insists that something be done immediately, you would be wise to evaluate the situation carefully before assuming that an emergency exists.

It is sometimes useful for patients or their relatives to visit the hospital before the time of admission. The pre-admission staff is glad to arrange appointments to talk things over. Some patients who are considering voluntary hospitalization, before making their decision, are taken to visit the ward where they will live.

Whenever the physician feels that he has information which may be useful, it is helpful if he gets in touch with the hospital himself. For example, a country doctor's call to me just before I admitted a patient led me to place an apparently debilitated woman, who arrived on a stretcher, in a ward with active young people instead of in a ward for the bedridden and senile. The results were infinitely better than might otherwise have been obtained.

The referring physician can also be of great help to the patient and the family during the course of hospitalization. You all know how troubled and mistrustful people can be at such times, particularly when questions of type of treatment or length of stay arise. The physician, if he himself understands what goes on in the hospital, can do a great deal to alleviate anxiety and to prevent premature removals from the hospital.

The staff of a psychiatric hospital, like any other group of physicians, seek satisfaction in their work through the successful treatment of patients. I can hardly overemphasize the critical role which the referring physician may play. My hope in this paper has been to communicate some of the ways in which you can assist your patients and your colleagues in the state hospital setting and to stimulate you to keep in touch with developments in the interesting and important field of hospital psychiatry.

19 West Cold Spring Lane Baltimore 10, Maryland

Clinico-Pathological Conference

from

PRINCE GEORGE'S GENERAL HOSPITAL

Joanna Sher, M.D.*

Presentation of Case

66-YEAR-OLD Negro woman was first admitted to Prince George's General Hospital on June 16, 1958, with the chief complaints of a cough productive of brownish sputum, pain in the left upper quadrant of the abdomen, and occasional vomiting of several weeks' duration. She also complained of severe hiccoughs during the 24 hours immediately before admission. Three weeks prior to admission she had visited her private physician and had been noted to have a temperature of 103 degrees F., rales in both lung fields, a distended abdomen, and an irregular pulse. She was digitalized and placed on antibiotics, with subsequent clearing of the rales. The pulse became regular, and the temperature returned to normal. The patient also complained at that time of abdominal pain, which steadily increased up to the time of admission. A large firm mass in the left upper abdominal quadrant was noted. One day prior to admission the temperature rose to 101 degrees F., and the severe hiccoughs developed. Anorexia and constipation accompanied the present illness. There was no history of melena or hematemesis. The past history and review of systems were noncontributory.

Physical examination on admission revealed a lethargic, elderly Negro female in no acute distress. T-100.4,P.-96, regular, B.P.-100/70, R.-20. The skin was dry and showed poor turgor. No

EDITOR'S NOTE: We acknowledge the efforts of E. C. H. Schmidt, M.D., of Memorial Hospital, Easton, who is attempting to secure Clinico-Pathological Conferences from various hospitals throughout Maryland. It is our hope that the CPC will become a regular feature of the Maryland State Medical Journal. We invite your comments.

lymph nodes were palpable. The chest had an emphysematous configuration with poor excursion. No dullness to percussion was noted. Coarse rales and rhonchi were heard bilaterally in a patchy distribution. The heart was not enlarged and no murmurs were heard. The abdomen was distended but non-tender. There was a palpable mass in the left upper quadrant extending below the costal margin, measuring 18x11 cm., which was rounded, smooth, firm, mobile, and slightly tender. This was interpreted as an enlarged spleen. The liver edge was palpable 2 cm. below the right costal margin and was rounded, smooth, and non-tender. Pelvic and rectal examinations revealed no abnormal findings. The extremities showed signs of weight loss.

On admission, the hemoglobin was 8.9 gms., Hct 32, RBC 3,750,000, WBC 9,600, with 67 polys, 22 lymphs, 9 band forms, and 2 monos. Urinalysis showed 2+ albumin and 14-16 WBC per high powered field. FBS was 94 mg. per cent and BUN 28 mg. per cent. Platelets were 36000/mm³. The prothrombin time was 100 per cent. BSP test showed 30 per cent retention.

An EKG taken two days after admission showed a sinus tachycardia (115/min.) and a digitalis effect.

^{*}Resident in Pathology, Prince George's General Hospital, Cheverly, Maryland.

The admission chest film showed mottled densities in both lung fields, most marked on the right, suggestive of pneumonitis. The heart was not enlarged. Views of the abdomen showed a large mass in the left upper abdomen, scattered calcifications in the right mid-abdomen and pelvis, and hypertrophic osteo-arthritis of the lumbar vertebrae. An upper gastrointestinal series and an intravenous pyelogram were negative. Repeat chest films during the patient's hospitalization showed increasing parenchymal infiltration of both lungs. On July 24 a pleural effusion was noted on the left. A film of the hand showed only arthritic changes of the proximal inter-phalangeal joints.

Additional laboratory tests done showed the following results:

- 1. Stools negative for ova and parasites.
- 2. Repeated gastric washings and tracheal aspirations negative for AFB.
- 3. Urine negative for Bence-Jones protein.
- 4. Sickle cell preparation negative.
- Total serum proteins: 7.9 gm. per cent Albumin: 3.4 gm. per cent Globulin: 4.52 gm. per cent
- 6. Direct Coomb's test-negative.
- Alkaline phosphatase—7.5 KAU.
 Thymol turbidity—13.1
 Bilirubin, total: 1.4, direct, 0.9, indirect, 0.5.
- 8. LE preparations, negative.
- Repeat Hb on July 6: 7.1 gm. per cent. Hct:28 RBC 2,950,000.
 WBC: 10,000 with 79 polys, 18 lymphs, 3 eos.
- 10. Febrile agglutinins: negative.
- Two bone marrow examinations. Within normal limits. No evidence of a granulomatous or malignant process.
- 12. PPD and histoplasmin skin tests: Negative.

The patient's hiccoughs were controlled by chlorpromazine. She ran a progressively downhill febrile course (T. 101 to 104), and did not respond to tetracycline or to penicillin therapy. There was increasing weakness, anorexia, and weight loss. Rales and rhonchi were observed intermittently. There was recurrent abdominal distention. The patient complained of no pain other than toothache.

On July 7, a scalene node biopsy was done. The nodes were replaced centrally by dense collagenous tissue and showed a peripheral rim of lymphoid tissue in which numerous small granulomas were visualized. These were composed of macrophages, lymphocytes, and giant cells of the Langhans type. There was no caseation present, and no inclusions were found in the giant cells. A definitive etiologic agent was not visualized.

On July 10, the patient was placed in isolation. She was treated with streptomycin, INH, digitoxin, and mol-iron, as well as occasional transfusions of whole blood and intravenous fluids. No favorable response was observed. On August 1, six weeks after her admission, the patient went into shock and died.

Discussion of X-rays and Differential Diagnosis

W. R. STECHER, M.D.: The increasing parenchymal infiltration scattered through both lung fields, as seen on the second chest film, is suggestive of either metastatic malignancy or so-termed alveolar carcinoma of the lung. The other possibility is that of a miliary spread of infection as one sees in a mycotic infection.

T. McGuire, M.D.: Just on the basis of the x-rays, could a tuberculous infection be ruled out?

DR. STECHER: Tuberculosis is unlikely. There is splenomegaly present. I am more inclined to the possibility of metastatic malignancy, possibly from the tail of the pancreas. No osseous metastasis is seen. The examination of the hand shows no osteolytic lesion suggestive of Boeck's sarcoid, nor does the fine patchy infiltration in the lungs suggest this (figs. 1 and 2).

Dr. McGuire: In the absence of evidence of malignancy elsewhere or of other metastasis, I would be inclined to favor a diagnosis of disseminated mycotic infection. This would explain the splenomegaly and the granulomatous lymphadenitis seen on scalene node biopsy. Although we were unable to show an etiologic agent in those sections, we saw no caseation which would suggest tuberculosis; nor did we see asteroid inclusions or Schaumann bodies, which are often seen in sarcoidosis. I definitely do not feel it is tuberculosis, in view of the negative cultures. A negative skin test can, of course, occur in a very ill patient with miliary tuberculosis. I do not know if this same phenomenon occurs in histoplasmosis, but again, we did not see any Histoplasma Capsulatum organisms. Although such infections are rare, I believe that in this case we must consider actinomycosis, nocardiosis, cryptococosis, blastomycosis,

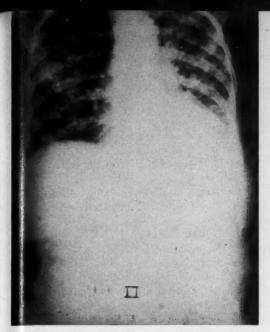


Figure 1: Chest x-ray taken six days prior to death.



Figure 2: X-ray of abdomen taken on admission.

and coccidioidomycosis. I see no note in the history as to whether the patient has ever lived in the San Joaquin valley, where coccidioidomycosis is endemic. An alveolar carcinoma of the lung would not explain the lymph node findings and the splenomegaly.

Dr. Stecher: I agree that an alveolar carcinoma does not fit in with the general picture, but I still feel that the x-ray picture is more suggestive of metastasis.

Dr. Raje: The patient had never been outside Maryland, as far as her relatives know. Do you think that the low platelet count was a manifestation of hypersplenism?

Dr. McGuire: In view of the normal bone marrow findings, yes.

Clinical Diagnosis

- Dr. McGuire: Disseminated mycotic infection, involving the lungs, spleen, and lymph nodes.
- 2. Dr. Stecher:
 - Metastatic malignancy to the lungs, possibly from the tail of the pancreas.
 - b) Mycotic infection
 - c) Miliary tuberculosis.

Anatomical Diagnosis

- 1. Disseminated North American Blastomycosis.
- 2. Multiple pulmonary emboli with infarctions.

Presentation and Discussion of Pathological Findings

At autopsy, the body was that of an elderly Negro female weighing 120 pounds and measuring 5'3". The lungs weighed 420 and 580 gms. and showed irregular white densities throughout, most prominent in the left apex. There was an adherent thrombus in the branch of the pulmonary artery to the left apex. The spleen weighed 880 gm. and showed capsular adhesions. The parenchyma was firm and yellow-white, with focal areas of reddish-gray pulp. The periaortic lymph nodes were enlarged, firm, and white. There was mild generalized arteriosclerosis. The liver, pancreas, kidneys, ureters, and urinary bladder were not grossly remarkable. Microscopic examination showed:

- 1. Granulomatous pneumonitis, with Blastomyces dermatitidis visualized on both H&E and PAS stains (fig. 3).
 - 2. Multiple pulmonary emboli.

Figure 3: Blastomyces dermatitidis in pulmonary alveoli. PAS stain. 440x.

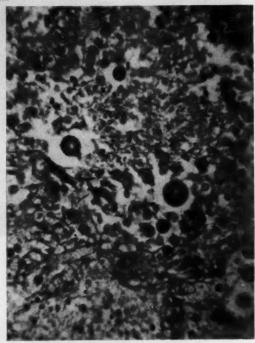


Figure 4: Section of spleen showing confluent granulomas, with a Langhans giant cell in the center, H.&E. stain, 100x.



- 3. Multiple pulmonary infarctions.
- 4. Multiple granulomata of the liver.
- Confluent granulomatosis of the spleen (fig. 4).
 - 6. Periaortic granulomatous lymphadenitis.
- Mild nephrosclerosis and chronic pyelonephritis.
 - 8. Chronic cystic cervicitis.
 - 9. Atrophy of the ovaries.

North American Blastomycosis is an infection caused by Blastomyces dermatitidis, an organism that is strongly pathogenic and causes destructive lesions in the skin, the lungs, and the bone. The organism is a round or oval fungus, 5 to 15 microns in diameter, and has a thick double-contoured wall. It reproduces by budding.

The clinical forms of the disease divided themselves fairly sharply into cutaneous and pulmonary blastomycosis. The pulmonary type is often complicated by systemic dissemination. The cutaneous form is characterized by microabscesses in the dermis, extending into the epidermis, surrounded by acute and chronic inflammatory exudates. Pseudo-epitheliomatous hyperplasia of the epidermis is common. Small granulomatous foci may be found within the areas of suppuration, containing Langhans giant cells. The pulmonary form produces miliary abscesses and granulomatous areas throughout the lung parenchyma. Occasionally the involvement is localized to a single area. Pulmonary blastomycosis is often confused with either carcinoma of the lung or tuberculosis. It usually becomes disseminated and is often fatal. Patients exhibiting a high antibody titre by the complement fixation test and low reactivity to the blastomycin skin test will probably die of the disease, whereas the outlook is entirely different for those reacting well to the skin test while the serum does not fix complement with blastomycin.

Therapy with potassium iodide, x-ray, surgical intervention, and vaccines have all been tried with some success. Stilbamidine and hydroxystilbamidine have given some promising results.

STUDY OF PELVIC CANCER

(Under the auspices of the Medical and Chirurgical Faculty and the Maryland Division of the American Cancer Society)

A Study of Delay in the Treatment of Pelvic Cancer

Howard W. Jones, Jr., M.D., and Mary E. McClelland

Cancer, established by the House of Delegates of the Medical and Chirurgical Faculty in 1951, has operated continuously except for a temporary suspension of activities in 1959, because of an injury to its secretary. With the purpose of studying the reasons for delay in bringing patients with cancer of the female generative organs under therapy, the committee's ulterior hope is that such case study will constantly alert all physicians to the fact that common and trivial symptoms may sometimes herald a malignant disease.

The long-time chairman of the committee has been Richard W. TeLinde, M.D., with Arthur L. Haskins, M.D., as co-chairman since 1957. Beverley C. Compton, M.D., has been the secretary. Serving on the committee at various times have been: Doctors H. M. Beck, F. Bloedorn, T. Bowyer, C. B. Brack, S. W. Christhilf, Jr., Osborne Christensen, R. N. Cooley, C. A. Cuccia, J. M. Dennis, J. R. Dickson, W. K. Diehl, E. S. Diggs, V. L. Ellicott, W. Faw, Jr., Gerald Galvin, W. H. Hanks, W. R. Hodges, Jr., J. M. Hundley, Jr., H. W. Jones, Jr., Theodore Kardash, R. F. Mattingly, F. K. Morris, R. S. Munford, Emil Novak, J. C. Sheehan, A. A. Sondheimer, O. H. Wood, and Mark Ziegler.

Delay on the part of the patient is said to have occurred if more than one month elapses from the onset of symptoms to the time the patient seeks medical attention. Delay attributed to the physician is said to have occurred if more than one month elapses from the time the patient presents herself to a physician until the initiation of definitive therapy. Delay attributed to house officer physicians is tabulated separately and called institutional delay. A few cases with grossly inade-

quate treatment have also been separately tabulated, as has delay due to laboratory error.

The pattern of this committee was taken from that of the various committees on maternal mortality, which have operated so successful for several years. Case deliberations of the committee have been published, from time to time, in the Maryland State Medical Journal.

Findings: General

Through 1958, 1,876 cases were classified by the committee.

Medical delay was found to be about the same for carcinoma of the cervix, fundus, and ovary, but somewhat higher for carcinoma of the vulva. Failure to make a pelvic examination at the time of the patient's initial visit was the chief cause of physician delay. The reasons for not making an examination were varied, a frequent reason being that the patient was bleeding at the time and was asked to return when the bleeding stopped. Medication was almost always prescribed, whether or not an examination was made. Often the patient was told that her symptoms were menopausal or due to "nerves" and were "nothing to worry about." Three post-menopausal patients were told that rather profuse vaginal bleeding was caused by high blood pressure and "is good for you." In many cases a pelvic examination was made, but the diagnosis not established. Again the symptoms were often considered menopausal,

The Committee for the Study of Pelvic Cancer meets monthly, October through May, for the discussion of selected cases. All physicians are cordially invited to attend these meetings.

Table I
Proportion of Pelvic Cancer Cases in Relation to Site and Cause of Delay

			Site of Cana	er, per cent		
Delay Agent	Cervix	Fundus	Ovary	Vulva	Vagina	Other
Physician	7	7	8	17	19	10
Physician and patient	7	5	8	8.5	6	7
Institution	2	2	3	8.5	0	7
Institution and patient	2.5	2	2	2	6	5
Institution and physician	0.4	0.5	1	0	0	0
Institution, physician and patient	0	1	0 .	0	0	0
Delay due to laboratory error	0.2	0.5	1	0	0	2
Inadequate or improper treatment	0.9	2	1	0	0	3
Patient	40	49	40	43	38	29
None	40	31	36	21	31	37
Combined medical delay	20	20	24	36	31	34
Combined patient delay	49.5	57	50	53.5	50	- 41

Table II

Delay in Relation to Site

1876 cases

		Patient	Combined patient	Medical	Combined medical
	Number		per ce	nt —	
Cervix	1321	40	49.5	.11	20
Fundus	277	49	57	12	20
Ovary	156	40	50	14	24
Vulva	47	43	53.5	25.5	36

40 50 14 24 43 53.5 25.5 36

	Stage O		Stage I Stage II		Stage III		Stage IV		Unclassified		Total		
	Num- ber	per cent	Num- ber	per cent	Num- ber	per	Num- ber	cent	Num- ber	per cent	Num- ber	per cent	
1951 (3 mo.) & 1952	39	17%	54	23 %	58	25%	54	23%	7	3%	21	9%	233
1953	31	18%	37	22%	35	20%	44	26%	10	6%	14	8%	171
1954	37	19%	54	27%	49	24%	35	18%	8	4%	15	8%	198
1955	48	22%	70	32%	51	24%	30	14%	4	2%	12	6%	215
1956	43	25%	61	35%	29	17%	21	11%	9	6%	10	6%	173
1957	43	26%	51	31%	29	18%	22	14%	10	6%	8	5%	163
1958	50	30%	46	27%	30	18%	31	18%	10	6%	1	1%	168
Total	291	22%	373	28%	281	22%	237	18%	58	4%	81	6%	1321

Cervical Carcinoma

and further diagnostic studies were not done. In the more recent years of the study, an increasing proportion of patients were examined, although there was still delay in establishing the diagnosis or referring the patient to a hospital or specialist for further study.

Patient delay was the same, 40 per cent, for

carcinoma of the cervix and carcinoma of the ovary; slightly higher, 43 per cent, in carcinoma of the vulva; and highest in fundal carcinoma, 49 per cent. Abnormal vaginal bleeding was the usual symptom in both cervical and fundal carcinoma, and the feeling that this was a normal part of the menopause was the greatest single fac-

Table IV

Delay in Cervical Carcinoma

10 10	No	No Delay		atient Delay	1 1000	edical Jelay	p	ical and atient Delay	Total
1951 (3 mo.)	rights 10	ATTENDED IN	1	115					000
and 1952	88	38%	102	44%	31	13%	12	5%	233
1953	52	30%	84	49%	19	11%	16	10%	171
1954	74	37%	87	44%	17	9%	20	10%	198
1955	81	38%	84	39%	27	12%	23	11%	215
1956	86	50%	50	29%	16	9%	21	12%	173
1957	70	43%	65	40%	8	5%	20	12%	163
1958	70	42%	61	36%	19	11%	18	11%	168
Total cases	521		533		137		130		1321

tor in causing patients to delay in seeking medical attention. Many and various reasons have been given, however.

125 patients "thought I was having the 'change.'"

110 patients "paid it no mind"; "did not think anything of it"; "did not think it could be anything"; "it did not seem to amount to much."

90 patients had minimal symptoms with only occasional vaginal spotting or discharge, or slight change in menses.

52 patients "thought it would stop."

46 patients "just put it off."

40 patients delayed because of financial reasons.

38 patients sought medical advice but did not follow the advice.

37 patients had an exaggerated fear of doctors and hospitals.

31 patients "felt perfectly well."

25 patients had other physical problems which were their chief concern.

21 patients delayed because of family problems or responsibilities.

21 patients considered the symptoms due to physical or emotional strain.

17 patients "did not think much of doctors."

12 patients "did not have a regular doctor and did not know where to go."

12 patients "did not worry until I had pain."

10 patients delayed because of embarrassment or modesty.

A few patients said, "I don't know why I didn't go to the doctor, but you know how you hate to give up." This was probably the reason with many. One patient who had been under the care of doc-

Table V

arcinom	1,32	1 cases	
No D	elay	Delay	,
246	47%	45	6%
146	28%	227	28%
63	12%	218	27%
36	7%	201	25%
4	1%	54	7%
26	5%	55	7%
_		-	
521		800	
	No D 246 146 63 36 4 26	No Delay 246 47% 146 28% 63 12% 36 7% 4 1% 26 5%	No Delay Delay 246 47% 45 146 28% 227 63 12% 218 36 7% 201 4 1% 54 26 5% 55

tors for two or three years regarding diabetes, arthritis, and other complaints was having intermittent postmenopausal bleeding during this time, which she did not report to her doctors. Her reasoning was that they did not ask her about it, so she did not tell them.

FINDINGS: CARCINOMA OF THE CERVIX

One of the most striking changes which has occurred in the years of the study has been the increase in the percentage of earlier cases of carcinoma of the cervix. In 1951-52, 40 per cent of all patients were classified as stage zero or stage one. By 1958, this figure has risen to 57 per cent. The detailed figures are given in Table III.

Curiously enough, a concomitant decrease in the delay factor, as calculated by the committee, is not clearly shown by the annual figures. (Table IV) It can be seen, however, that there is a consistently larger percentage of cases showing no delay in the years since 1955. Our arbitrary 30-day interval as a measure of delay makes it somewhat difficult to estimate the delay period. A breakdown of the cases showing no delay in 1953 revealed that nine per cent of the cases showed no

loss of time; i.e., were under medical care immediately. In 1958, 20 per cent of the cases showed no loss of time. The devestation of delay-patient or medical-is more clearly revealed by the data of Table V.

SUMMARY

Over a period of about seven years, 1,876 cases of cancer of the female pelvic organs were studied for causes of delay in bringing patients under therapy. The results of this study are tabulated in the body of the paper. During the years under study there was a tendency for patients with carcinoma of the cervix to be seen earlier in the course of their disease. There were insufficient patients with other forms of pelvic cancer to be analyzed for this point. Although the committee can scarcely claim credit for the progressively earlier treatment of carcinoma of the cervix found by the investigation, its existence was certainly one of the factors bringing about this desirable result.

COURSE IN POSTGRADUATE GASTROENTEROLOGY

The American College of Gastroenterology announces that its annual course in Postgraduate Gastroenterology will be given at the Bellevue-Stratford Hotel in Philadelphia on October 27, 28 and 29, 1960.

The faculty will be drawn from the medical schools in and around Philadelphia. The subject matter to be covered in the course, from a medical as well as surgical viewpoint, will be essentially the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum. There will be a clinical session at the Albert Einstein Medical Center, and again this year, in addition to individual papers, there will be panel discussions and CPC's of interest.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

SOCIETY FOR CLINICAL AND EXPERIMENTAL HYPNOSIS

Willard Hotel, Washington, D. C., October 6-7. Lester S. Blumenthal, M.D., 5315 Connecticut Ave., N.W., Washington 15, D. C.

Permanent Chairman

Workshops in Clinical Hypnosis will be conducted October 5. For information write the Institute for Research in Hypnosis, 33 East 65th Street, New York 21, New York.



ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

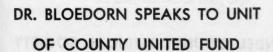
LESLIE E. DAUGHERTY, M.D.

Journal Representative

DR. SKITARELIC TELLS ROTARIANS ABOUT MEDICAL PATHOLOGY

BENEDICT SKITARELIC, M.D., deputy medical examiner for Allegany County and Cumberland pathologist, discussed "Newer Trends in Diagnostic Medicine" at a meeting of the Frostburg Rotary Club. Pointing out that the medical field of pathology is a relatively new specialty in the United States, he described the pathologist as the "unknown man of medicine" who is often referred to as a "doctor's doctor." Years ago, he told his audience, a doctor would give a prescription containing many ingredients in the hope that at least one would cure the illness, a method which is known as the "shotgun method" of treatment.

As for medical examiners, Dr. Skitarelic said the system in Maryland is one of the best in the United States. Any death in which the cause is unknown is referred to the medical examiner, who is a pathologist.



Pernando G. Bloedorn, M.D., head of the division of radiotherapy and associate professor of radiology at the University of Maryland School of Medicine, addressed a recent dinner meeting of the Board of Directors of the Health Research and Services Foundation of County United Fund, held at the Cumberland Country Club. Dr. Bloedorn is a consultant at a cancer clinic held in Cumberland once a month under the auspices of the Foundation.

W. Royce Hodges, M.D., chairman of the Re-



search Committee, presented a Cancer Research Grant of \$5,000 from the Foundation to the Cancer Research Program of the School of Medicine, University of Maryland. Wylie M. Faw, Jr., M.D., Cumberland, is president of the Foundation, and A. J. Mirkin, M.D., is treasurer. Leo H. Ley, Jr., M.D., is a member of the Health Education Committee, and Donald B. Grove, M.D., serves on the Direct Services Committee.

PERSONALS

JAMES H. EVANS, M.D., radiologist, has joined the staff of Garrett County Memorial Hospital. Dr. Evans is a 1948 graduate of Jefferson Medical College, Philadelphia. He was certified by the American Board of Radiology in June 1960.

L. Michael Glick, M.D., Cumberland, has been elected a member of the Board of Directors of the Allegany-Garrett County Heart Association.

At one of the monthly Medical-Surgical Chest

Disease Conferences at the Cumberland Memorial Hospital, Abdul S. Hashim, M.D., presented a discussion of "Viral Infections of the Respiratory Tract." L. Michael Glick, M.D., reviewed and evaluated the "Diagnostic Approach to Pleural Effusion."

A dinner meeting of the Allegany-Garrett County Medical Society was held June 15 at the Cumberland Country Club. The speaker was Robert A. Hingson, M.D., Department of Anesthesia at Western Reserve University School of Medicine, whose subject was "Trouble Spots in the Middle East." The physicians' wives were guests. W. Royce Hodges, M.D., was the sponsor

Leslie E. Daugherty, M.D., Cumberland, has been appointed by Governor Millard J. Tawes to a three year term on the Advisory Council on Hospital Construction.

Bowie Linn Grant, M.D., nephew of William F. Williams, M.D., and Richard J. Williams, M.D., Cumberland, is opening an office in Oakland.

Dr. and Mrs. Wyand F. Doerner, Jr. have returned from a vacation in Franklin, North Carolina and Miami Beach, Florida. Dr. Doerner attended the meeting of the American Medical Association in Miami.

W. O. McLane, M.D., Frostburg, was



A. J. Mirkin, M.D., standing beside his Mercedes-Benz, is a member of both A.M.A. and Faculty committees on automobile accidents.

selected to be master of ceremonies at the Beall High School alumni reunion, 1960. He is a graduate of the University of Maryland, School of Medicine.

A. J. Mirkin, M.D., Cumberland, has been appointed to the American Medical Association Committee on Medical Aspects of Automobile Injuries and Deaths. He is also serving for the second year on the Medical and Chirurgical Faculty's Committee on Prevention of Highway Disasters.

Dr. and Mrs. Thomas F. Lewis, of Cumberland, announced the birth of a son, John Keller, on June 15.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

THE REGULAR MEETING of the Anne Arundel County Medical Society was held on May 18, 1960, at the Officers Club of the Naval Academy. A social hour and dinner was held, after which the meeting was called to order. About 60 per cent of the society members attended the meeting.

Karl Mech, M.D., legislative chairman of the State Society, brought the members up to date concerning the national Samuel Borssuck, M.D.

Journal Representative

legislation of particular interest to the medical profession. His talk was well received and was followed by a number of questions and quite a discussion from the floor, which reflected the interest of the members on this topic.

The society noted the recent death of Stanley

Sargent, M.D., of the Crownsville State Hospital. Dr. Sargent had been a member of the society for many years.

The matter of emergency coverage for the county was again discussed, and a motion was passed that several committees be appointed for the various geographical areas of the county to make some specific plans for their particular area. Four members were elected to active membership from their previous courtesy membership status. Three new members were also elected to the society.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative



SPECIAL MEETING of the Executive Board was called on Tuesday, May 31, at 6 P.M. to consider the revised report of the Committee to Investigate the Care of Private Patients at Baltimore City Hospitals. Although Dr. Pierpont, the chairman, was not present, President Diggs went over the wording, phrase by phrase, with the Executive Board. Many substitutions were considered, but the changes to which the committee could be expected to agree were narrow, as determined by President Diggs and members of the Executive Board who had met with the committee. After full and careful discussion, the Executive Board went on record as favoring the report and authorized calling a special meeting of the membership, as early as possible before summer vacations, to review the revised report, rather than waiting until the next regular meeting in October.

THE EXECUTIVE BOARD'S regular meeting was held on June 14. Among the items considered was a reply from the Board of Medical Examiners to our inquiry about the law concerning the prescribing of drugs by chiropodists. In his letter, Frank J. Morris, M.D., secretary of the State Board of Medical Examiners quoted the annotated code of Maryland, Article 43, Section 453, as follows: Chiropody as defined by this subtitle is the diagnosis, surgical, medical, or mechanical treatment of all ailments of the human fcot. The term "surgical treatment" is defined

for the purposes of this subtitle as limited to the cutting or surgery performed on the soft tissues of the foot, superficial to the deep fascia, and to the toes; with the amputation of a toe or toes and the use of an anesthetic, other than local, prohibited. The secretary went on to quote the opinion of the Attorney General as follows: . . . the chiropodist is permitted . . . to use local anesthetic. The term "medical" would clearly indicate that chiropody could include the application of medicated preparations to the feet, and we believe it is generally understood that some chiropodists use preparations in the form of salves and ointments. In the "1926 Opinions of the Attorney General," this office held that chiropodists were authorized to use narcotic drugs in preparing local anesthetics, and medicated preparations to use in connection with the treatment of the feet. By letter . . . it was held that chiropodists could administer penicillin as part of a minor surgical operation. It would therefore seem clear that a chiropodist has the right to prescribe such drugs as he may deem necessary to prevent infection or for the treatment of ailments of the human foot.

The Executive Board unanimously felt that the law, as so defined, had not kept pace with the advance of modern therapy. In the several instances referred by us to the Board of Medical Examiners, where chiropodists had prescribed dangerous drugs (cortisone to an individual with peptic ulcer, known to his physician but not to the chiropodist, for example), the hazard of non-medical prescription of potent drugs is indeed greater than it was at the time the opinions of Attorney General were given. The Executive Board voted to appeal to the State Medical Society Council that a definition of "medical treatment" be put in the law to limit the medical care chiropodists legally give as effectively as the limitations which now limit surgical care to be "within the scope of their professional competence." The Executive Board asks that this be done soon lest other and more serious incidents occur.

Samuel Morrison, M.D., reported on the Red Cross Blood Bank meeting. Representatives from hospitals and interested medical organizations had met to discuss administrative details in the blood bank setup in the Baltimore area. Dr. McDonnell called attention to the fact that in San Francisco the medical society operates the blood bank and wondered why there the profession was so insistent on control. Dr. Morrison assured the Executive Board that in Metropolitan Baltimore the Red Cross was unanimously the preferred administrative clearing house for blood bank problems.

A report was received from the Public Relations Committee regarding a proposed medical supplement in a Sunday newspaper. Progress in obtaining 200-word articles for use in such a supplement was gratifying, but the newspaper found difficulty in financing it. As of this time, the project is in a state of suspended animation, and it is the opinion of the committee chairman that nothing is likely to come of it.

The July and August meetings of the Executive Board were cancelled, unless some special business needs attention. The next meeting will be in September, just before the Semiannual Meeting of the Faculty.

Finally, the Journal Representative

was taken to task regarding anonymity at Executive Board Meetings. Individuals are not to be identified with their opinions without express consent in each instance; otherwise members may fail to express themselves for fear of being quoted. (The open Society meetings are another matter.) Firmly convinced that "names make news," your Representative will, nevertheless, preserve Executive Board anonymity hereafter. This matter brings up an important point: not only the Executive Board, but the membership of the Society is asked to make constructive criticism of this column.

T WAS EXCEEDINGLY warm when more than 250 members of the Society found their way to the Greek Orthodox Church for the special meeting of the Baltimore City Medical Society on Monday, June 20, 1960. The auditorium-gymnasium was, in some ways, an improvement over Osler Hall, having better acoustics and, while the fans were going, better air-conditioning. As the audience grew and the fans were turned off to permit better hearing, it became hot and humid.

President Everett Diggs opened the meeting with a statement of its purpose. He called attention to the presence of the professional parliamentarian, Mr. William Evans, and asked the members to adhere strictly to Robert's Rules of Order, to discuss principles and not personalities.

Ross Z. Pierpont, M.D., chairman, Committee to Investigate the Care of Private Patients at Baltimore City Hospitals, read his committee's report in full, carefully phrased and with considerable emphasis. He moved that it be accepted, which motion was promptly seconded from the audience.

Francis P. Chinard, M.D., acting chief of medical service at Baltimore City Hospitals, was first to discuss the motion. He declared that since Baltimore City Hospitals was the "target for tonight," he wanted to emphasize the side of the

picture as he saw it. Defining the purpose of the hospital as "to provide as good medical caré as possible to the indigent sick," he pointed out that "first rate medical care cannot be provided to the indigent in a hospital restricted in scope to this group. The group comprises the very old, the pregnant, and the chronically ill whose financial resources have been exhausted." For a hospital to have the complex medical facilities and good house staff necessary to provide "the quality of medical care expected by the community," Dr. Chinard maintained, "the hospital must have a more usual pattern of patients than the restricted group I've mentioned." He also championed the right of patients able to pay to make their own choice of physician and hospital. "A citizen of Baltimore who wishes to be treated at the City Hospitals should not be denied that right because he is willing or able to pay."

Disclaiming the professed inability of the committee to obtain an admissions audit for the "given period," April 1 to June 30, 1958, he offered the following facts made available to him: Of 4,159 admissions during the first five months of 1960, 6.8 per cent (283 patients) paid for professional care. Of the number who provided professional fees, 113 had Blue Shield as the source, 110 had commercial insurance, 19 had Workmen's Compensation, and 51 paid their own fees. In 1959, the grand total of professional fees paid was \$80,313.70; \$48,503.50 from Blue Shield and \$31,810.20 from other sources.

Mr. Daly, of the City Auditor's office, was called upon to produce statistics. He said he had been directed by his office to endeavor to obtain what information the Baltimore City Medical Society wanted, but in such a manner that no identification of individuals would be possible. He complained that this limitation had made it a most difficult task; but of the 151 cases audited over the period selected, seven professional fees, totaling \$515, had been billed. He gave an

assortment of other statistics too rapidly to be caught by the "naked ear."

Donald Proctor, M.D., describing himself as a physician who had been full-time but was now in private practice, said, "I am surprised to hear nothing, in this report on private patient care at the Baltimore City Hospitals, on the *character* of that care. It would be unfortunate for this group to go on record as considering this question purely on economic grounds without showing interest in the *character* of the care given the patient."

Alexander J. Schaffer, M.D., reading a prepared statement, "in the interest of brevity and temperateness," challenged first that aspect of the report setting up the illegality of payments to hospitals. He stated that the question of legality was moot, and that a minor change in legal procedure would make it perfectly proper. Dr. Schaffer called attention to the small number of cases involved. He raised the issue of polio admissions and other properly public health and consultant service matters. His final appeal was that we should not permit this magnificent medical institution to regress again to the Bay View of old.

M. B. Levin, M.D., spoke to the point that these are public funds and we are dealing with a public, not a private hospital. It "could have no restrictions or discriminations limiting the treatment of private patients either to the reserved hospital staff treating welfare or indigent cases or to other reserved closed staffs in the favor of those running the hospital." He said, "The hospital for the purpose of treating private patients would have to be an open hospital, the patient having the right to treatment by his own personal physician as long as that physician was in good standing as determined by the State Medical Examiners (with its Qualifying and Disqualifying Boards). The welfare or indigent cases, who do not have their own physicians, may be treated by physicians hired for that purpose by the city or state. The others, paying their own way completely or through private insurance for that purpose or through subsidized insurance (Blue Cross), will be permitted to have their own doctors treat them under those conditions, if the City Hospital is designated an open hospital by the city authorities for that purpose. If subsequent similar hospitals be established in various metropolitan areas of the community, north, east, south and west, all must be open hospitals."

Donald Mintzer, M.D., related a recent personal experience in which during his absence from the city, his private patient had been admitted to the City Hospitals as an emergency. As a favor to the patient's wife, Dr. Mintzer went out personally and nonprofessionally to visit the patient. As his personal physician, he found a great deal of difficulty in getting to see him. He had to go through a bureaucracy to the director of admissions, who said that "since he was just visiting," he couldn't be allowed to go in except during visiting hours. Dr. Mintzer declared this incident left a bad taste in his mouth. Whatever administration they have at Baltimore City Hospitals, he felt it should be a more democratic one.

John F. Hogan, Jr., M.D., reminded us again of the change in the admission policy at the City Hospitals reported between 1954 and 1958, saying that if the authorities of City Hospitals want to broaden the elective private admissions, there is really no predicting what their attitude would be in 1962 or 1966—at similar four-year intervals.

Dr. Warfield Firor pleaded that we "cut right to the heart of the matter, for what affects Baltimore City Hospitals affects all the hospitals in Baltimore." Baltimore physicians, he said, assume three variations of attitude to hospitals:

- a) the scientific, in which every patient is a guinea pig
- b) the commercial, which considers every patient a customer with a

purely business approach to hospital practice

c) the artistic, in which every patient is a person, and the primary aim of the physician is to be of service

He warned that the effect of this resolution would be to set the pattern in all hospitals, that insurance fees would go into the pockets of a few selfish M.D.'s.

James G. Arnold, Jr., M.D., commented that "the problems concerning the Baltimore City Hospitals are very complex, but in my opinion, the basic issue is whether or not the Baltimore City Medical Society wanted to go on record as favoring the corporate practice of medicine under City auspices. He stood with the AMA in its continuing opposition to the corporate practice of medicine at any level."

The final speaker of the evening was James S. O'Hare, M.D., who agreed with Dr. Arnold and proceeded to amplify this approach to the committee's report. He defined the corporate practice of medicine for us as the hiring of licensed M.D.'s for a salary by lay individuals or organizations, the employer billing the patient for the services rendered by the physician, a definition from official AMA sources. He noted that at first physicians generally looked on only as interested spectators while anesthetists, roentgenologists, and pathologists struggled under the effect of corporate practice of medicine for hospitals. At first it involved only them. Allied with advocates of corporate practice in the field of hospital administration is a small segment of the medical profession, primarily full-time physicians engaged in university teaching. In Dr. O'Hare's opinion, although believing in their sincerity, the full-time teachers are unwittingly prepared to sacrifice the good of the whole profession for their own limited ends. With quotations from a large variety significantly authoritative sources, including the University of Maryland, he spelled out at length how this has led to vigorous competition of some university hospitals with private practitioners for the private paying patient.

Dr. O'Hare turned again to the AMA's strong reasoning against the corporate practice of medicine. The corporate practice of medicine again and again was declared unethical in many publications of the official organization of American physicians. Dr. O'Hare read and quoted them chapter and verse. In a dramatic parliamentary action, while the members sat spellbound, he moved

the question—seconded and carried by a two-thirds standing vote. Further debate stopped, and the report was voted on. For this written ballots were decreed. Since the ballots had to be signed to prove eligibility to vote, they were anything but secret. After an agreeably brief interval, the result of the balloting was given: of 250 votes cast, one was unsigned and thus discarded; in favor of the motion, 157; opposed to the motion, 92. The meeting adjourned and, with a strong general tone of set-lipped intransigence that could almost be grasped, the groups and sub-groups left the great hall of the Greek Orthodox Church.



BALTIMORE COUNTY MEDICAL ASSOCIATION

WILLIAM H. F. WARTHEN, M.D.

Journal Representative

THE REGULAR MEETING of the Baltimore County Medical Association, Inc., was held at 1:00 P.M., at the Penn Hotel, Towson, Thursday, May 28. Vice-president Margaret L. Sherrard, M.D., presided in the absence of the president.

Dr. Sherrard read a telegram from the Legislative Committee of the Faculty urging members to express to their Congressmen their opposition to the adoption of the Forand Bill. The bill is presently in the House Ways and Means Committee.

William A. Pillsbury, M.D., read the Nominating Committee's slate of officers for 1960-1961: President, Margaret L. Sherrard; Vicepresident, Frank T. Kasik, Jr.; Secretary-treasurer, Elizabeth Sherrill; Delegates, Martin B. Strobel, Melvin B. Davis, Frederick A. Holden, D. Delmas Caples; Alternates, Charles H. Williams, David Andrews, George S. M. Kieffer, Clarence E. McWilliams. This slate was unanimously accepted.

Charles Williams, M.D., reporting on the Civil Defense program he attended in New York, stated that about a year ago the President and Congress had delegated the United States Public Health Service to be the responsible agency for medicine and medical care in time of emergency. Since July 1, 1958, the Office of Civil and Defense Mobilization has been established within the Executive Office of the President. Its director is a member of the National Security Council and attends meetings of the President's cabinet. Thus, the line of authority for civil defense medical services flows from the Executive Office of the President through the OCDM regional office to the state civil defense medical services to the local civil defense medical services. The local responsibility for the direction of these services is that of the local health officer, William H. F. Warthen, M.D., who will be in charge of health and medical services in Baltimore County in time of an emergency. Dr. Strobel would serve as disaster chairman under the direction of the health officer.

Dr. Williams reported that 120 doctors from the Middle Atlantic states were in attendance for

a week of intensive study regarding the defense of our nation. The instructors were members of the Army, the Navy, and top medical men. A lecture was given on the attitudes of the people, which is always a problem. Dr. Williams expressed his hope that the physicians would recognize the problem and assume leadership by preparing themselves and their families. An atomic disaster could wipe out half the country. If half is left it is enough to start again. The matter of potential national disaster is a real thing. Populations have been decreased by tremendous numbers, because of earthquakes and tidal waves. It is important to prepare now. Prepare your office, your practice, and your family for civil or national disaster. Dr. Williams went on to say that the auxiliary of our Association has selected Civil Defense as their project for the coming year, and the members were urged to support this project.

Dr. Sherrard introduced the speaker, Robert E. Ensor, M.D., director of the Anticoagulant Clinic at Mercy Hospital, who talked about "The Use of Anticoagulants in Cerebral-Vascular Disease." A question and answer period concluded the session.

Mary E. Matthews, M.D., director of Child Health Services of the Baltimore County Health Department, announced that physicians are needed for the child health clinics in the Dundalk, North Point, and Catonsville areas.

FREDERICK COUNTY MEDICAL SOCIETY

L. R. SCHOOLMAN, M.D. Journal Representative

A DISCUSSION OF "Common Dermatoses," by R. C. Vail Robinson, M.D., highlighted the May 17 meeting of the Frederick County Medical Society at the Francis Scott Key Hotel. Dr. Robinson's presentation evoked an appreciative response from the members in attendance.

Robert Turner, M.D., has discontinued his general practice in Frederick. He will spend two years of training in University Hospital, after which he plans to practice anesthesiology.



MONTGOMERY COUNTY MEDICAL SOCIETY

CHARLES FARWELL, M.D.

Journal Representative

PETER LOMBARD, M.D., has returned to practice after his recent illness, and he is said to be more distinguished looking than ever with a well-trimmed Van Dyke. Soon after recovery from his sickness, Peter was attending the committee meeting for the Silver Spring Hospital Building Fund.

Progress goes forth on the Silver Spring Hospital, to which many of our members have given so much.

G. L. Gold, M.D., has been elected a member of the American Association for Cancer Research. Robert A. Bier, M.D., for 30 years a member of the medical staff of the Christ Child Hospital, Rockville, was presented a special award by Archbishop O'Boyle on behalf of the Christ Child Society.

William Peeples, M.D., Montgomery County health officer, spoke to our Medical Society on "Chronic Diseases." He was assisted by several able speakers who also presented interesting scientific data concerning the availability and use of health resources for treatment of long term illnesses.

The Washington Sanitarium and Hos-

MARYLAND STATE MEDICAL JOURNAL

pital in Takoma Park was commended and congratulated by our Society for holding a day-long refresher course for rescue squad personnel. Delbert R. Dick, M.D., deserved and received credit for arranging this program, which included the following brief talks: welcome by John Brownsberger, M.D.; Patient Ventilation, Erwin Chapman, M.D.; General Emergencies, Lysle Williams, M.D.; Rescue Squad Procedures and Disciplines, Merrill Cross, M.D.; Medical, Charles Wolohon, M.D.; Neurological, John Lord, M.D.; Orthopedic, Henry Jaeger, M.D.; Otolaryngic, Elmer Lorenz, M.D.; Thoracic, Marvin Kolkin, M.D.; Obstetrical, Raymond Chinn, M.D.; Pediatric, Allen B. Coleman, M.D.; and Psychiatric, Cyril Hardy, M.D.

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Merrill Cross, M.D., chairman of our Emergency Medical Care Committee, stated that 132 men from 22 rescue squads attended the refresher course and each of them was enthusiastic. It is hoped that the hospital will give a similar course again and will allow a longer time for each presentation. It would be well if other hospitals provided a refresher course for rescue squads in their communities.

The Montgomery County Tuberculosis and Heart Association's president wrote a letter expressing gratitude on behalf of the many people who listened to our volunteer physician speakers. He stated that this generous giving of time and talent by busy physicians is a tribute to their deep concern for their fellow man and an outstanding contribution to the heart program.

The speaker's bureau takes recognition of the medical health educational efforts of Irene Barrett, M.D. She made four talks to four different audiences: "Developing the Feminine Personality" at Meadowhall School; "Mollie Grows Up" at Bethesda Elementary School; "A Medic Looks at Sports Leadership" to the American Association for Health Physical Education and Recreation at Miami, Florida; and "Sex Education" to the Girl Scouts.

Abraham Danish, M.D., gave two talks: "Heart Attacks—How to Have Them—How to Prevent Them" to the Current Comment Club of Montgomery County and "Uterine and Breast Cancer" at the Silver Spring Library.

William H. Killary, M.D., spoke on "Heart Attacks—How to Have Them—How to Prevent Them" at the Community Meeting of Cabin John Citizens.

Herman C. Maganzini, M.D., spoke on "Heart Attacks—Coronary Heart Disease" to the Gaithersburg-Washington Grove Volunteer Fire Department.

Max C. Sherer, M.D., spoke on "Radioisotopes

in Medical Practice" to the Montgomery County Nurses Association.

The Montgomery County Medical Society pledged its cooperation to make successful the polio clinics where its physician members donate their time and services. These clinics entitle anyone who so wish to obtain polio protective shots at no cost to themselves. They are made possible through the generosity our own Doctors of Medicine, the County Health Department, or the County Board of Education.

The American Rhinologic Society will hold its sixth annual meeting October 8 at the Belmont Hotel, Chicago. Physicians are invited; there is no registration fee.

WASHINGTON COUNTY MEDICAL SOCIETY

GEORGE JENNINGS, M.D. Journal Representative

THE WASHINGTON COUNTY Medical Society held its bimonthly meeting at 5:30 P.M., May 19, 1960. The scientific portion of the meeting was devoted to a consideration of "Coronary Atherosclerosis" by J. Scott Butterworth, M.D., vice president of the American Heart Association and associate professor of medicine at the New York University Postgraduate Medical School.

The remainder of the meeting was devoted to the business affairs of the Washington County Medical Society. A number of projects are under consideration, such as civil defense, the proposed incorporation of the local society, and problems of aging.

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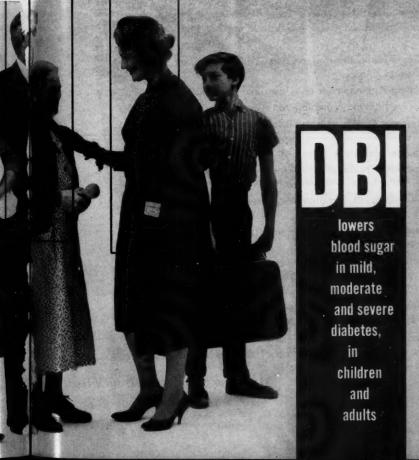


TEMPORARY LIBRARY QUARTERS

T IS OUR PLEASURE to inform our members throughout the state that the library will continue to function during the renovations to the building at 1211 Cathedral Street. Temporary quarters have been secured just a stone's throw from the Faculty building. It is a large room on the second floor of the American Realty Company building, situated on the corner of Cathedral and Preston Streets, with its own entrance on Preston Street. There we shall move a skeleton collection: the more important journals issued since 1940 and recent textbooks and monographs. These, together with the reference tools which may be accommodated in the available space and a telephone, should be sufficient for an adequate but somewhat curtailed service for our members. New books will be added as usual, and collections of books for county medical society meetings will be available. Regular work will continue, and library hours will not change.

We hope that you will continue to use the library services, and we crave your indulgence for any shortcomings due to circumstances beyond our control.

> Louise D. C. King Librarian



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Maryland SOCIETY OF PATHOLOGISTS INC.

Louis B. Thomas, M.D., President

EDWARD C. McGARRY, M.D., Secretary Suburban Hospital, Bethesda, Md.



THE SEROLOGIC TEST FOR SYPHILIS

Syphilis, its origin lost in antiquity, was named in the year 1530, and its causative agent was described in 1905. Although a complement fixation test devised by Wassermann appeared the following year, the search for a better test for syphilis continues.

Until World War II, the tests for syphilis depended upon the detection of a non-specific antibody or *reagin* in the patient's serum. Biologically false-positive reactions do occur with this test. It has been the hope of numerous investigators that a test employing a specific antigen would provide a means of distinguishing between biologically false-positive and true-positive blood tests for syphilis, or if used routinely false-positive reactions would be avoided.

The search for more specific tests has centered about the use of the causative agent itself, *Treponema pallidum*. Some of the tests which have resulted from this search are listed.

- 1949 Treponema pallidum Immobilization test uses viable T. pallidum organisms —(Nichols strain) as antigen.
- 1953 Treponema pallidum Agglutination test-uses viable T. pallidum.
- 1953 Treponema pallidum Immune Adherence test—uses non-viable T. pallidum.
- 1955 Treponema pallidum complement fixation test—uses protein extract of T. pallidum.
- 1956 Treponema pallidum Methylene Blue test-uses non-viable T. pallidum.
- 1956 Whole-body Treponema pallidum Complement Fixation test—uses non-viable T. pallidum.
- 1957 Reiter Protein Complement Fixation test—uses protein from avirulent Reiter treponeme.
- 1957 Treponemal Wassermann Reaction test—uses fraction of *T. pallidum* obtained by mechanical disruption.
- 1957 Treponemal Fluorescent Antibody test—uses non-viable T. pallidum with patient's serum and fluorescein tagged rabbit anti-human gamma globulin serum.
- 1958 Treponema pallidum Cryolysis Protein test—uses protein fraction obtained by cycles of freezing and thawing of T. pallidum.

Time and expense preclude the routine use of many of these treponemal tests in the diagnosis of syphilis; however, the introduction of the Rapid Plasma Reagin



BALTIMORE CITY HEALTH DEPARTMENT

HUNTINGTON WILLIAMS, M.D.

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City Tuberculosis Report

In a New Publication giving tuberculosis statistics in the United States for the year 1958, the U. S. Public Health Service has recorded the City of Baltimore as having the highest tuberculosis case and death rates among the country's largest cities. While this is not a new experience for Baltimore, the report re-emphasizes the fact that Baltimore still has a serious tuberulosis problem.

The high tuberculosis death and case rates in Baltimore City do not necessarily reflect a lack of an adequate tuberculosis control program but rather that these rates result from the racial and socio-economic character of the city. After Washington, D. C., Baltimore has the highest per cent of nonwhite population among the 10 largest cities. The Negro tuberculosis rates are approximately two to three times higher everywhere than are comparable white rates.

In reviewing the Baltimore experience for the past decade, it is reassuring to note that the tuberculosis death rate in 1950 was 56.4 per 100,000 population; whereas in 1959 it had dropped to 14.8 per 100,000, a decrease of 74 per cent. The case rate, likewise, has declined but not quite so dramatically. In 1950 the case rate was 142 per 100,000, and in 1959 it was 84.4 per 100,000, a decline of 41 per cent.

Huntington Williams, N.D.

Commissioner of Health

Test, which uses unheated serum or plasma, has proven to be equal in efficiency to the more lengthy standard reagin procedures. It is slightly more sensitive than the VDRL slide test; but loses little specificity as a reagin procedure. It can be performed with a minimum of equipment and personnel, and results are available within ten minutes.

The false-positive reactors may be eliminated from those positive with the Rapid Plasma Reagin Test by the use of the Reiter antigen test or the fluorescent antibody test. In the Fluorescent Antibody test, non-specific reactions may be eliminated by diluting the test serum 1/200, and positive serum reacts effectively at much higher dilutions. W. E. Deacon of the United States Public Health Service has reported the specimens found to be anticomplementary in the TPCF test and inconclusive in the TPI test, due to penicillin or unknown toxic factors, may yield positive findings in the fluorescent antibody procedure. This test is currently being evaluated and may become the test of choice in the future.



Heart Page

Frank W. Davis, Jr., M.D. - Editor

SERVICE OF

THE HEART ASSOCIATION OF MARYLAND

Evaluation of Patients with Potential Coronary Disease

Frank W. Davis, Jr., M.D.

ESPITE THE WIDESPREAD interest in and awareness of coronary heart disease, no 'critical" diagnostic technique is available to the general physician which allows him to diagnose this disease with objective certainty, except when myocardial infarction has occurred, with electrocardiographic and other confirmatory evidences of the event. Doubtless, the patient whose history is that of classical angina pectoris promptly relieved by rest is not usually a problem in diagnosis. On the other hand, the subject with vague chest pains, upper abdominal discomfort, shoulder, back, or arm pain, or with fatigue or other symptoms, thought possibly to represent myocardial ischemia, is not ordinarily diagnosed with the same degree of confidence. Similarly, the subject whose multiple psychogenic symptoms are accompanied by potentially cardiogenic pain and the subject who is asymptomatic but in whom objective evidence of coronary normalcy is needed for insurance or other purposes cannot be definitively appraised by historical and physical review.

The extensive efforts to utilize "stress" tests in the past, the multiple applications of serological (lipid), electrocardiographic, and other laboratory methods, attest the awareness of investigators that a major deficiency in clinical cardiology exists in the study of this most widespread and serious disease of our population. It is the purpose of this discussion to review briefly the methods which seem to be of some value at the present time.

It should be apparent to all physicians that the historical facts are, in large measure, the most important; but this report is concerned only with techniques in which objective documentation is possible.

The widespread use of the electrocardiogram (resting) has led many to feel that this record is a sine qua non in diagnosing ischemic heart disease. Unfortunately, nothing could be further from the fact. Less than 25 per cent of patients with angina pectoris have abnormal electrocardiographic tracings (1). Of the small number of patients in whom an abnormal pattern is found, relatively few have "diagnostic" changes, most showing "non-specific" alteration in the ST-T portion of the record.

Electrocardiographic exercise tests, using a wide variety of exertional stresses and evaluated by observing post-exertional BCG changes (about which there is no real agreement among "authorities") have been the most extensively studied diagnostic technique (other than resting ECG). Space prohibits a detailed documentation of this method; it is sufficient to emphasize that many pitfalls await the unwary physician. As many as 25 per cent of normal subjects may develop ECG changes which are considered "positive" for coronary disease by some physicians (2). Subjects with autonomic lability are especially prone to develop "false positive" responses. On the other hand, patients with established coronary heart disease show "positive" responses (0.5 mm. ST segment depression) in only 50 per cent of subjects studied in this laboratory (2) in contrast to the much higher incidence reported by Master (3). It should be emphasized that the ECG exercise test is truly "positive" when ST

From the Department of Medicine, Johns Hopkins University School of Medicine and Johns Hopkins Hospital, Baltimore, Maryland.

segment depression of 1.5 mm. or more occurs after exercise, usually in a precordial lead, and with a contour which is characterized by depression of the J (RS-segment junction), "flattening" of the ST segment, with or without T or U wave changes. Tachycardia after exercise prohibits adequate evaluation. Other electrocardiographic stress tests have proved of rather limited value. Electrocardiographic changes after the creation of anoxemia, after administration of pitressin, ergonovine, epinephrine, and other drugs have been found useful by some investigators, but have not proved generally acceptable because of the risk involved and the failure of these methods to add significantly to the information obtained with exercise.

The ballistocardiograph has been widely studied with expressed hopes that this instrument might facilitate the segregation of normal from diseased subjects. It has proved useful only in the young patient (under 40) if abnormal and in the elderly (over 60) if normal (1). The ballistocardiogram is more helpful when used as a means of monitoring the stress of smoking. Approximately half of patients with coronary disease show an abnormal BCG response to smoking, which is in contrast to the 7 per cent "positives" in normal controls (4).

Specific diagnostic value cannot be assigned to various ancillary data, but when viewed as part of the "coronary profile," there are certain readily available facts that can be considered. These data

should include (a) careful family history for genetic appraisal, (b) the presence of and degree of hypertension, (c) age, (d) sex, (e) smoking history, (f) background of "tensions," (g) level of and pattern of serum lipids, and (h) degree of obesity.

When all of the diagnostic methods considered have been utilized and carefully correlated with history and physical examination, most subjects can be categorized as "relatively normal" or probably having significant coronary obstruction. There remains a segment in which, despite all efforts, definitive information cannot be obtained. In this category, especially in centers fully familiar with the technique, visualization of the coronary arteries with radio-opaque media seems justified. This method has been used by our group (5) largely as a means of selecting patients for coronary artery surgery; but when definite need exists for the utmost in objective documentation, it would seem to be, at present, the final resort of the clinician. The most satisfactory visualization is with cine-angiocardiography, although excellent details of coronary structure are obtained with conventional methods.

REFERENCES

- Scarborough, W. R., et al: Am.Heart J. 44:645, 1952. Davis, F. W., et al: Am.Heart J. 46:529, 1953. Master, A. M., et al: Am.J.M.Sc. 207:435, 1944. Davis, F. W., et al: Am.Heart J. 51:165, 1956. Lang, E. K., Sabiston, D. C., and Davis, F. W.: Unpublished observations

published observations.

astern Section, American Trudeau Society and Northeastern Tuberculosis Conference Emerson Hotel, Baltimore, Md. Friday and Saturday, October 28-29

NINTH U. S. CIVIL DEFENSE COUNCIL CONFERENCE MEDICAL - HEALTH SECTION

> September 21-22, 1960 Minneapolis, Minnesota

OCEAN CITY MEETING FRIDAY, SEPTEMBER 16, 1960



Woman's Auxiliary Medical and Chirurgical Faculty

HYGEIA CE

MRS. E. RODERICK SHIPLEY Auxiliary Editor

August, 1960

FUTURE NURSES HOLD EIGHTH ANNUAL CONVENTION

PARKVILLE SENIOR HIGH School was the scene of the eighth annual convention of the Future Nurses of Maryland, which took place April 30. Students from the host club aided in the registration of all guests and gave a favor to each student registrant.

The meeting formally opened with an invocation by the Reverend Frederick D. Eyster, of Frederick, Maryland, father of the president of the Future Nurses of Maryland. Mary Ellen McKim, president of the Parkville club, gave a brief message of welcome, after which Sue Eyster presided over the business meeting.

Election of officers was the main item of business. By written ballot the following candidates were elected:

PRESIDENT: Cathy Cribbs, Milford Mill High School

PRESIDENT-ELECT: Carolyn Bere, Frederick High School

RECORDING SECRETARY: Mary Creed, Frederick High School

CORRESPONDING SECRETARY: Marie Brewer, Franklin High School

TREASURER: Geraldine Deems, Dundalk High School

HISTORIAN: Wilma Newberry, Franklin High School

PARLIAMENTARIAN: Grace Dennis, Havre de Grace High School

In an impressive candlelight ceremony, the new officers were installed by the Reverend Frederick Eyster. A candle was lit for each officer as she pledged her service.

The achievement award was won by Boonsboro High School, which last year had tied for the honor. Mrs. William S. Stone, president of the Medical and Chirurgical Faculty, presented the award. Honorable mentions were given to Frederick High School, Parkville High School, Westminster High School, and Forest Park High School. Reports were submitted from 17 clubs in competition for the award, and the following report is that of the winning Boonsboro School:

Club members marched in two parades; they won second prize for organized clubs in the Halloween parade, and three-fourths of the members marched in the Armistice Day parade. Favors for 255 trays were made for the local hospital for Thanksgiving Day dinner. Christmas dinner trays had favors of a small Santa Claus carrying a filled nut cub as his pack. In November, 50 girls with two advisors and two mothers visited three hospitals in Washington, D. C., Bethesda Naval Center, and Georgetown University. Some of the members helped start a Junior High Future Nurse Club in Boonsboro Junior High School. Speakers in medical fields were featured: Mr. Richard Hajek, head of Maryland Medical Secretarial Schools; Miss Leasure and Mrs. Devilbiss, of City Hospitals, who spoke on the opportunities and the training of practical nurses; Miss Henrietta Lyle, laboratory technician, who spoke about her job and showed a film on the training and work of a laboratory technician; Mr. Robert Shestack, physiotherapist at Washington County Hospital, who told about his specialty. A question and answer period followed each talk.

The Boonsboro chapter was granted its National Charter in February, the fifth club in



Officers old and new. In the front row are the incoming officers, left to right: Carolyn Bere, Mary Ellen Creed, Marie Brewer, Geraldine Deems, Wilma Newberry, Grace Dennis. In the back row are the outgoing officers, left to right: Frances Surrath, Betty Carr, Florence Speigel. The Reverend Frederick Eyster is in the background.



Sue Eyster, president, registers as Parkville students man the registration desk.



Above: Miss Eleanor Arnett Nash was the guest speaker,

Below: Mrs. William S. Stone, president of the Woman's Auxiliary to the Medical and Chirurgical Faculty, presents achievement award to representative of Boonsboro Future Nurse Club.

the state to qualify. A Valentine dance drew an attendance of more than 250 and earned a profit of more than 40 dollars. Cookies and punch were served, and a queen of hearts was crowned. During the year this club trained 20 girls to work in the snack bar of Washington County Hospital and, all in all, they have given 456 hours of volunteer service. Fifteen members have taken a standard Red Cross first aid course. Their big project for this year and for the next five years is the establishment of the LeVan Scholarship Fund of the Boonsboro Future Nurse Association. One hundred fifty dollars has been put in the bank for this fund toward the ultimate aim of one thousand dollars. Except when



specifically noted, the entire club of 60 members have worked on all projects undertaken. Delegates have attended all State Future Nurse Club meetings. Boonsboro, this year, published seven issues of the "Candlelight Express," the official newspaper.

A coke break was observed at 11 A.M., during which time the Parkville Future Nurse Club and their sponsor, Mrs. Louise Parsons, the school nurse, demonstrated what delightful hostesses they could be.

The guest speaker was Miss Eleanor Arnett Nash, whose topic was "Opportunities Galore— No Goal Too High." She proved to be a witty, charming, and invigorating person, and her talk could not fail to inspire her audience to strive on even if the going is rough.

Luncheon was served at noon in the school cafeteria for a small fee, after which everyone enjoyed a teen-age fashion show sponsored by the Hecht Company, Northwood. Ten club members, each representing a different high school, served as models.

The Maryland Student Nurse Choir, under the direction of Mrs. Martha Pointer, entertained with a half hour of song. The balance of the day was spent touring the exhibits of the hospital training schools. In a session for sponsors and advisors, mutual problems and plans were discussed. Our Auxiliary can be proud to be the sponsors of such a fine group of students.

STUDENT AMERICAN MEDICAL ASSOCIATION AUXILIARY

MEMBERS OF THE S.A.M.A. Auxiliary were hostesses at a Dean's Day Tea, held in connection with the graduating ceremonies at the University of Maryland Medical School. The tea was held on the lawn adjacent to the hospital and the new student union building. Five kinds of tea sandwiches, iced punch, and cookies were served.

At the graduation exercises, the senior students' wives were awarded a Mrs. Doctor diploma, en-

titling them to all the joys, trials, and tribulations of being a doctor's wife.

The following letter was composed by a member of S.A.M.A. Auxiliary and distributed to every medical student and to every medical student's wife. Our thanks for the assistance that such action has given the legislation program and our compliments on the efficient manner in which it was done.

KNOW YOUR MEDICAL LEGISLATION Courtesy Women's Auxiliary—S.A.M.A.

The enclosed pamphlets concerning the Forand Bill (HR 4700) point up a problem that is of vital concern to the future of each medical student, his wife and family. While the Forand Bill may not be brought to the floor of the legislature for a vote, committees of both the Senate and House of Representatives are presently inquiring into the question of health insurance coverage for the aged. Informed sources believe that some form of health insurance legislation will be brought to a vote during this session of Congress. The fact that this is an election year will promote the consideration of this kind of legislation.

It is both our responsibility and prerogative as citizens and future members of the medical profession to:

1. BE INFORMED. Follow the daily reports concerning the present hearings.

Watch for any new legislation that is introduced. Read some of the articles available concerning health care and the aged.

- 2. THINK. There are two sides to every question—these pamphlets represent the views of the American Medical Association, but also read what the proponents of the Forand Bill have to say. Reaching your own decision will serve to strengthen your own beliefs. We are certain, however, that when you have considered all of the facts, you will oppose the Forand and similar bills.
- 3. SPEAK UP. Remember that WE are the government. We merely entrust our "voice" to elected officials. It is therefore imperative that each and every one of us write our Representative and Senator stating our reasons for opposing passage of the Forand Bill and similar legislation. DO NOT leave it to "the others" to do!

Once you become informed and think about the proposals before our legislature, we are certain you will realize that the discussions presently taking place in Washington, D. C., in your state capitol, and home town may have a great effect on your future. Let us accept our responsibility and help our representatives make the right decisions.

If you do not know who your Representative or Senators are, either Pratt Library or one of the local newspapers can furnish you with this information.

CALENDAR OF EVENTS

► Monday, September 12 ◀

SACRED HEART HOSPITAL MEDICAL STAFF 11:30 A.M. School of Nursing, Bellevue Street, Cumberland

► Tuesday, September 13 ◄

MARYLAND SOCIETY ON ALCOHOLISM
Officers and Executive Committee
8:00 P.M. Council of Social Agencies,
22 Light Street

▶ Wednesday, September 14 ◀

MARYLAND SOCIETY FOR MENTALLY RETARDED CHILDREN GREATER BALTIMORE CHAPTER 8:15 P.M., 2525 Kirk Avenue

► Thursday, September 15 ◀

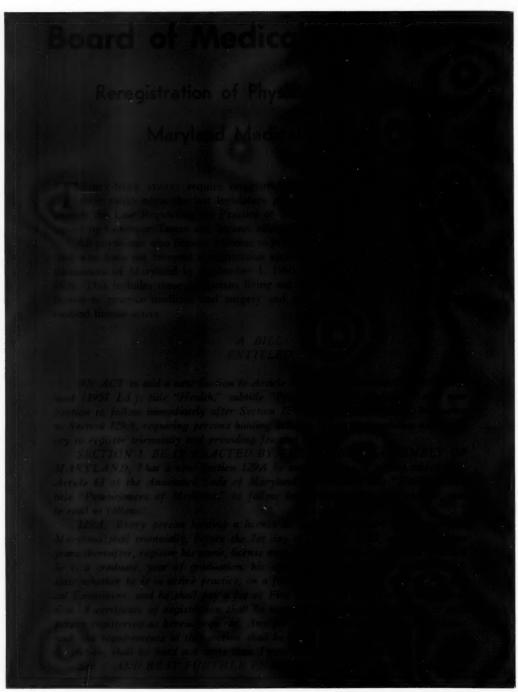
MARYLAND OBSTETRICAL AND GYNECOLOGICAL SOCIETY 6:30 P.M. Beach Plaza, Ocean City Cocktail Party and Dinner Meeting COL. H. L. RIVA—"Experience with Vaginal Delivery following Previous Cesarean Section"

► Friday, September 16 ◀

MEDICAL AND CHIRURGICAL FACULTY
OF MARYLAND
Ocean City Meeting—Commander Hotel

▶ Saturday, September 17 ◀

9:30 A.M.-12:30 P.M.
Commander Hotel, Ocean City



Frank K. Morris, M.D., Secretary Board of Medical Examiners of Maryland

DIRECTORY*

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

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LIST OF PRESIDENTS-1799-1960

1799-1801-Upton Scott.
1801-1815-Philip Thomas.
1815-1820-Ennals Martin.
820-1826—Robert Moore.
326-1836-Robert Goldsborough.
1836-1841-Maxwell McDowell.
341-1848—Joel Hopkins.
1848-1849-Richard Sprigg Steuart.
1848–1849—Richard Sprigg Steuart. 1849–1850—Peregrine Wroth.
1850-1851-Richard Sprigg Steuart.
1851-1852-William W. Handy.
1852-1853-Michael S. Baer.
1853-1854-John L. Yeates.
1854-1855-John Fonerden.
1855-1856-Jacob S. Baer.
1856-1857-Christopher C. Cox.
1857-1858-Joshua I. Cohen.
1858-1859-Joel Hopkins.
1859-1870-Geo. C. M. Roberts.
1870—John R. W. Dunbar.
1870-1872-Nathan R. Smith.
1872-1873-P. C. Williams.
1873-1874-Charles H. Ohr.
1874-1875-Henry M. Wilson.
1875-1876-John F. Monmonier.
1876-1877—Christopher Johnston.
1877-1878Abram B. Arnold.
1878-1879—Samuel P. Smith.
1879-1880-Samuel C. Chew.
1880-1881-H. P. C. Wilson.
1881-1882—Frank Donaldson.
1882-1883-William M. Kemp.
1883-1884—Richard McSherry.
1884-1885-Thomas S. Latimer.
1885-1886-John R. Quinan.
1886-1887—George W. Miltenberger.
1887-1888—I. Edmondson Atkinson.
1888-1889-John Morris.

1889-1890-Aaron Friedenwald. 1890-1891-Thomas A. Ashby. 1891-1892-William H. Welch. 1892-1893-L. McLane Tiffany. 1893-1894-George H. Rohé. 1894-1895-Robert W. Johnson, 1895-J. Edwin Michael. 1895-1896-Charles G. Hill. 1896-1897-William Osler. 1897-1898-Charles M. Ellis. 1898-1899-Samuel C. Chew. 1899-1900-Clotworthy Birnie. 1900-1901—Samuel Theobald. 1901-1902-J. McPherson Scott. 1902-1903-William T. Howard. 1903-1904—Eugene F. Cordell. 1904-1905-Edward N. Brush. 1905-1906-Samuel T. Earle, Jr. 1906-1907-Hiram Woods. 1907-1908-Charles O'Donovan. 1908-1909-Brice W. Goldsborough. 1909-1910-G. Milton Linthicum. 1910-1911-Franklin B. Smith. 1912-Hugh M. Young. 1913-Archibald C. Harrison. 1914—Randolph Winslow. 1915-J. W. Humrichouse. 1916-J. Whitridge Williams. 1917-Guy Steele. 1918-William S. Halsted. 1919-John Ruhräh. 1920-James E. Deets. 1921-William S. Gardner. 1922-Arthur H. Hawkins. 1923-Herbert Harlan (Jan.-Aug.). Harry Friedenwald (Aug.-Dec.).

1926-Thomas B. Johnson, Deceased December 25, 1925. 1926-Josiah S. Bowen. 1927-Thomas S. Cullen. 1928-Peregrine Wroth, Jr. 1929-Alexius McGlannan. 1930-Henry M. Fitzhugh. 1931-J. M. H. Rowland. 1932-Eldridge E. Wolff. 1933-J. Albert Chatard. 1934-George O. Sharrett. 1935-J. M. T. Finney, Sr. 1936-Frederick D. Chappelear. 1937-Arthur M. Shipley. 1938-Frank B. Hines. 1939-Dean Lewis: Acting President, Victor F. Cullen. 1940-Edward P. Thomas. 1941-Harvey B. Stone. 1942-R. Lee Hall. 1943-Charles R. Austrian. 1944-Jacob W. Bird. 1945-Carroll Lockard. 1946-Thomas R. Chambers. 1947-William T. Hammond. 1948-Charles W. Maxson. 1949-W. Houston Toulson. 1950-A. Austin Pearre. 1951-Walter Dent Wise. 1952-Alan M. Chesney. 1953-Maurice C. Pincoffs. 1954—Bender B. Kneisley. 1955-George H. Yeager. 1956-William H. F. Warthen. 1957-C. Reid Edwards. 1958-J. Sheldon Eastland. 1959-Leslie E. Daugherty. 1960-Whitmer B. Firor.

1799-1848—(Unknown.) 1848-1849—John Readel, Jacob Baer, P. Wroth. 1850-1851—Joel Hopkins, P. Wroth, Jacob Fisher. 1851-1853—(Unknown.)

*Transactions, 1960.

LIST OF VICE-PRESIDENTS

1924-Philip Briscoe.

1925-Lewellys F. Barker.

1853–1854—John Fonerden, Albert Ritchie, P. Wroth.

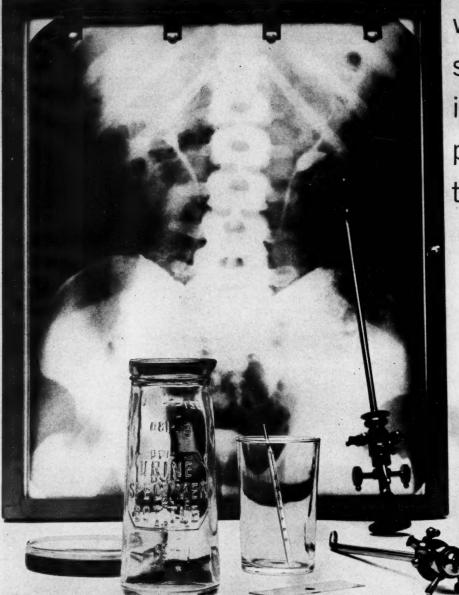
1854-1855—George C. M. Roberts, Samuel P. Smith, Joel Hopkins.

1855-1856-George C. M. Roberts,

G. W. Miltenberger, M. Diffenderffer.

1856–1857—P. Wroth, Wm. H. Davis, Samuel Smith.

1857–1858—William Waters, Frederick Dorsey, Joel Hopkins.



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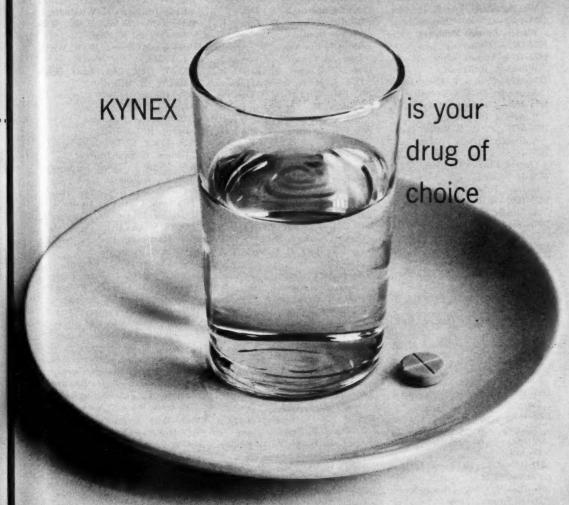
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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antiblotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antiblotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



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1871-1872-C. H. Ohr, Edward Warren, Richard McSherry.

1872-1873-(Unknown).

1873-1874—Samuel Chew, H. M. Wilson, A. B. Arnold.

1874-1875-Francis T. Miles, James A. Steuart, D. A. O'Donnell.

1875–1876—Christopher Johnston, A.B. Arnold, J. C. Thomas.1876–1877—P. C. Williams, James

1876-1877—P. C. Williams, James A. Steuart, Francis T. Miles.

1877-1878—S. C. Chew, F. E. Chatard, Charles H. Jones.

1878-1879—James C. Thomas, L. McLane Tiffany.

1879-1880-H. P. C. Wilson, James A. Steuart.

1880-1881-L. McLane Tiffany, G. Ellis Porter.

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1894-1895-Charles H. Jones, W. M. Nihiser.

1895-1896-Charles G. Hill, Clotworthy Birnie.

1896-1897—Wilmer Brinton, Randolph Winslow.

1897-1898—W. F. A. Kemp, George J. Preston.

1898-1899-Mary Sherwood, J. Mc-Pherson Scott. 1899-1900-Samuel Theobald, David Streett.

1900-1901-Samuel T. Earle, Jr., J. B. R. Purnell.

1901-1902—Harry Friedenwald, B. W. Goldsborough.

1902-1903—Samuel T. Earle, Jr., Wilmer Brinton.

1903-1904—Franklin B. Smith, James M. Craighill.

1904–1905—Samuel T. Earle, Jr., D. C. R. Miller, Julius A. Johnson. 1905–1906—Charles O'Donovan, Thomas M. Chaney, Joseph B. Seth.

1906-1907-William T. Watson, Philip Briscoe, William F. Hines.

1907–1908—Roger Brooke, Henry L. P. Naylor, George Dobbin. 1908–1909—Philip Briscoe, William

L. Smith, G. Milton Linthicum. 1909–1910—Philip Briscoe, A. P.

Herring, Compton Riely. 1910–1911—J. Staige Davis, H. B. Gantt, Timothy Griffith.

1912—J. L. Riley, D. E. Stone, J. A. Chatard.

1913—J. Staige Davis, C. F. Davison, E. B. Claybrook.

1914—C. R. Winterson, A. L. Franklin, Gordon Wilson.

1915—A. McGlannan, J. E. Deets, R. Lee Hall.

1916—L. C. Carrico, M. D. Norris, J. A. Chatard.

1917—D. E. Stone, A. H. Hawkins, J. M. H. Rowland.

1918—Julius Friedenwald, J. E. Dets, J. McF. Dick.

1919—J. McF. Bergland, Philip Briscoe, J. E. Deets.

1920—T. R. Boggs, A. M. Shipley, Eugene Jones.

1921—J. H. M. Knox, Jr., A. H. Hawkins, C. E. Davidson.

1922—Harry Friedenwald, W. R. White, J. S. Bowen.

1923—J. M. H. Rowland, Harry Friedenwald, Peregrine Wroth, Jr. 1924—C. Urban Smith, J. Percy Wade, E. E. Wolff.

1925—J. S. Bowen, T. B. Johnson, J. McF. Dick.

1926—Standish McCleary, G. Roger Myers, S. A. Nichols.

1927—Standish McCleary, John L. Riley, Frank S. Keating.

1928—J. Albert Chatard, F. B. Hines, R. T. Miller, Jr.

1929—Henry M. Fitzhugh, Robert P. Bay, Thomas R. Boggs. 1930—F. D. Chappelear, W. T. Hammond, F. B. Hines.

1931-W. D. Campbell, H. M. Lankford, Charles Maxson.

1932—W. T. Hammond, John T. King, Jr., Lewis K. Woodward.
1933—S. A. Nichols, E. H. Hut-

chins, W. S. Seymour. 1934—G. C. Lockard, W. R. White.

J. L. Riley. 1935—J. McF. Dick, Louis Hamman, V. D. Miller.

1936—Harvey G. Beck, Norman S. Dudley, Jesse O. Purvis.

1937—Harvey B. Stone, W. A. Gracie, R. Lee Hall.

1938—Frank S. Lynn, Richard C. Dodson, Everard Briscoe.

1939-Victor F. Cullen, Frederic V. Beitler, William D. Noble.

1940—Edward P. Smith, H. A. Cantwell, Charles L. Owens.

1941—Guy L. Hunner, Charles R. Foutz, R. Lee Hall.
1942—Maurice C. Pincoffs, Wm. F.

Williams, Jacob W. Bird. 1943—Charles Reid Edwards, A.

Austin Pearre, J. Oliver Purvis. 1944—Alan M. Chesney, William D. Campbell, Hugh R. Spencer.

1945—William N. Palmer, Harry R. Slack, Armfield F. Van Bibber.

1946—William D. Noble, Grant E. Ward, John S. Green, Jr.

1947—Huntington Williams, Frank M. Wilson, J. Herbert Bates. 1948—William Neill, Jr., Baltimore;

1948—William Neill, Jr., Baltimore; Samuel E. Enfield, Cumberland; M. Seton Waesche, Snow Hill.

1949—Amos R. Koontz, Baltimore; O. H. Binkley, Hagerstown; P. E. Cox, Easton.

1950—I. Ridgeway Trimble, Baltimore; Vincent H. Davis, Chesapeake City; Thomas K. Galvin, Baltimore.

1951—Samuel McLanahan, Baltimore; Frank D. Worthington, Frederick; Frank W. Smith, Chestertown.

1952—Frank J. Geraghty, Baltimore; W. A. Gracie, Cumberland; Deceased 12-28-51; William F. Williams, Cumberland; R. Carmichael Tilghman, Baltimore.

1953—George O. Eaton, Baltimore; Osborne D. Christensen, Salisbury; William F. Williams, Cumberland.

1954-E. Paul Knotts, Denton;

Ernest I. Cornbrooks, Jr., Baltimore; Ralph G. Hills, Baltimore, 1955—Waldo B. Moyers, Hyattsville; Samuel Whitehouse, Baltimore; Charles J. Foley, Havre de

1956—Beverley C. Compton, Baltimore; Ernest F. Poole, Hagers-

Grace.

town; Henry A. Briele, Salisbury. 1957—James T. Marsh, Westminster; A. C. Dick, Chestertown; Richard W. Te Linde, Baltimore.

1958—Archie R. Cohen, Clear Spring; Alfred R. Maryanov, Cambridge; Grant E. Ward, Baltimore. 1959—Robert W. Farr, Chestertown; Page C. Jett, Prince Frederick; Samuel Morrison, Baltimore.

1960—Edmond J. McDonnell, Baltimore; Merrill M. Cross, Silver Spring; Harold B. Plummer, Preston.

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Davis, John R., 6629 Charlesway—

Davis, Marvin Hersch, 6512 Liberty Road—7

Davis, W. Bowdoin, 600 W. Belvedere Avenue—10

†Day, Newland E., 4 East 33rd Street —18

Deane, Garrett E., 5402 Edmondson Avenue—29

De Borja, Pedro S., 1020 Armistead Way—5

†Debuskey, Matthew, 2505 W. Belvedere Avenue—15

De Carlo, John, Jr., 701 Seabrook Court—4 Deckelbaum, Joseph 4017 Liberty

Deckelbaum, Joseph, 4017 Liberty Heights Avenue—7

Deckert, W. Allen, 1114 St. Paul Street—2 †De Groot, Volckherdt M., 14 W.

Mt. Vernon Place—1 De Hoff, George W., 2020 N.

Charles Street—18 †De Hoff, John Burling, Loch Raven Shopping Center, Northern Park-

Shopping Center, Northern Parkway and Loch Raven Boulevard —12 Deibel, Harry, 5417 Purlington Way

—12 Delfs, Eleanor, Johns Hopkins Hos-

pital—5
Demarco, Salvatore J., Jr., 715 N.

Charles Street—1 †Dennis, John Murray, University Hospital—1

Denny, Walter L., Brady Urological Inst., The Johns Hopkins Hospital—5

de Quevedo, Theodore G., Kenilworth, Cockeysville, Md.

Desbordes, Lionel A., 2930 Baker Street—16

De Vincentis, Michael Louis, 1202 St. Paul Street—2

Dickson, Robert John, 3905 Canterbury Road—18

†Diehl, William K., 11 E. Chase Street-2

Diener, Louis, 2449 Eutaw Place— 17

†Diggs, Everett S., 11 East Chase Street—2 Di Paula, Anthony F., 5301 Harford Road—14

†Dix, Harold C., 405 N. Charles Street—1

Dixon, Alfred Burton, 3501 St. Paul Street, Apt. 5—18

†Dixon, D. McClelland, 819 Medical Arts Building—1 Dixon, William T., 600 W. Belve-

dere Avenue—10 †Dobihal, Louis Charles, 447 N. Ken-

wood Avenue—24 Dodd, William A., 700 N. Charles

Street—1 Doeller, Charles H., Jr., 5600 Har-

ford Road—14 Donner, Leon, 4023 Brookhill Road

—15 Doran, William T., Jr., 110 Carroll

Street, S.E., Washington 3, D. C. †Dorf, Herman J., 7404 Liberty Road-7

†Dorman, John W., Jr., 3101 St. Paul Street—18

Douglass, Carleton C., 15 East Biddle Street—2

Douglass, Louis H., Mount Custis, Accomac, Va.

Doukas, James A., 4008 Bedford Road—7

Drenga, Joseph F., 209 S. Chester Street—31 Drozd, Joseph, 240 S. Ann Street—

31 Dubash, Darabsha Burjorji, Sinai

Hospital—15 Dudley, Albert Henry, Jr., 1201 N.

Calvert Street—2 Duffy, William C., 1120 St. Paul

Street—2 Dugan, Francis M., 15 East Biddle Street—2

†Dugan, Hammond J., Jr., 15 East Biddle Street—2

Dumler, John C., Medical Arts Building—1

Dumler, John Donald, Medical Arts Building—1

Dunnigan, William C., 1800 North Charles Street—1

Duvall, Robert C., 811 Stags Head Road—4

†Dwyer, Frank P., Jr., 5315 Springlake Way—12

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†Eaton, George O., 4 E. Madison Street—2

Eaton, W. Drummond, 7215 York Road—12

Eavey, James L., 3901 N. Charles Street—18

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Ebeling, Karl W., 5200 Tilbury Way —12

†Ebeling, William Carl, 809 Medical Arts Building—1

Edel, J. Wesley, Charleston Hall, Charles & Cold Spring Lane—10 Edgerton, Milton T., Johns Hopkins Hospital—5

Edmonds, Charles William, 2746 The Alameda—18

*Edmunds, Page, Gibson Island, Md. Edwards, C. Reid, 314 Medical Arts Building—1

Edwards, Monte, Medical Arts Building—1

Ehrlich, Daniel, 701 Cathedral Street—1

Eisenberg, Leon, 2610 Whitney Avenue—15

Elder, Franklin C., 2201 Echodale Avenue—14

†Elgin, William W., Sheppard & Enoch Pratt Hosp.—4

Enoch Pratt Hosp.—4 †Ellis, Francis A., 8 E. Madison

Street—2 †Ellison, Emanuel S., 107 E. West Street—30

Eney, R. Donald, 12 York Road—4 Englehart, William P., 2 East Read Street—2

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Everett, John Thomas, 3501 Fait Avenue—24

*Ewald, August Ludwig, 36 York Court—18

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†Faraino, Frank A., 2 West Read Street—1

†Farber, George J., 1037 St. Paul Street-2

Farber, Mary S., 305 Woodlawn Road—10 Farber, Robert E., 305 Woodlawn Road—10

Farfel, Harold S., 1047 Ingleside Avenue—28

Farley, Francis E., 416 Chumleigh Road—12

†Fearing, William L., 3025 Belair Road—13

Feinglos, Israel J., 2002 E. Pratt Street—31

Feldberg, Theodore M., 5504 South Bend Road—9

Feldman, Maurice, Jr., The Latrobe, Charles and Read Streets—2

Feldman, Maurice, Sr., 7121 Park Heights Avenue—15

Feldman, S. Charles, 1440 E. Baltimore Street—31

†Fenby, John S., 3522 Greenmount Avenue—18

Ferguson, W. Richard, 600 W. Belvedere Avenue—10

Fetter, William Joseph, 3101 St. Paul Street—18

†Field, Arnold Lewis, 901 Cathedral Street—1

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†Finberg, Laurence, 6811 Pimlico Drive—9

†Fine, Jack, 2601 Steele Road—9 Fineman, Jerome, 4004 Liberty Heights Avenue—7

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Finkelstein, Ruth, 801 Medical Arts Building—1

†Finney, D. C. W., 1103 Harriton Road—10

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†Firor, Whitmer B., 1100 N. Charles Street—1

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Fisher, A. Murray, 18 E. Eager Street—2

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Fitzpatrick, William N., 300 Somerset Road—10

Fleischer, Walter E., 3400 E. Chase Street—13

Flippin, Eugene L., 4403 Underwood Road—18

Flynn, Philip D., 203 Taplow Road

—12

Fordyce Class V. 1001 St. Paul

Fordyce, Cless Y., 1001 St. Paul Street—2

†Fort, Wetherbee, 1118 St. Paul Street—2

Foster, Herbert M., 2824 St. Paul Street—18

†Fox, Samuel L., 1205 St. Paul Street—2

Fox, Thomas Edward, Hospital for the Women of Maryland—17

Frank, Jerome D., 603 West University Parkway—10

†Franklin, Haswell D., 1123 St. Paul Street—2

†Franz, John Howard, 2938 St. Paul Street—18

†Fravel, C. Richard, 926 Beaverbank Road-4

Freedom, Leon, 1031 St. Paul Street—2

†Freeman, Norman Randolph, Jr., 210 Northway—18

†Frenkil, James, 338 W. Pratt Street
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Frey, Edward L., Jr., 4605 Edmondson Avenue—29Frey, E. William, 1928 Pennsyl-

vania Avenue—17
Fried, Hiram, Medical Arts Build-

Fried, Hiram, Medical Arts Building—1

Friedenwald, Edgar B., Marlborough Apts., 1-B, 1701 Eutaw Place—17

†Friedman, Hyman P., 1319 Light Street-30

†Friedman, Marion, 5211 Harford Road—14

Frieman, Sylvan, 8342 Merrymount Drive—7

Friskey, George H., 4815 Wilkins Avenue—28

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Fritz, William F., 2 W. University Parkway—18

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Futcher, Palmer H., Department of Medicine, Johns Hopkins Hospital—5

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Gaines, Leonard M., Jr., 213 So. Tyrone Road—12

Gaither, Ernest H., 12 E. Eager Street-2

Gakenheimer, W. Alfred, 3805 Belair Road—13

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Galleher, Earl P., 3414 St. Paul Street—18

Galvin, Gerald A., 322 Suffolk Road

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Gann, Mark E., 1010 St. Paul Street-2

Gans, Jack S., 1401 Reisterstown Road—8

Gantt, William Horsley, Johns Hopkins Hospital—5 Gareis, Louis C., 1651 Northwick

Court—18 †Garis, Robert William, 1103 St.

Paul Street—2 Garlick, William L., 700 N. Charles

Street—1 Garrison, Alfred S., 2 East Read

Street—2 Gaskel, Jason H., 637 S. Conkling Street—24

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Gebhardt, Robert William, 3711 Monterey Road—18

Gehlert, Sidney R., Jr., 4700 Pennington Avenue—26

Geldrich, John, 5932 Clayton Avenue-6

Gellman, Moses, 2500 Eutaw Place
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Genecin, Abraham, 714 Park Ave-

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Geraghty, William R., 309 Northway—18

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Gerwig, John M., Jr., 400 Gralan Road—28

Gibbons, J. Robert, 3 Elmhurst Road—10

Gillis, Andrew C., 1033 N. Calvert Street—2 Gilmore, William E., 108 E. 33rd

Street—18 Gimbel, Harry S., 4605 Edmond-

son Avenue—29 †Ginsburg, Leon, 529 N. Charles

Street—1 Glass, Frederic A., 845 Park Ave-

nue—1 Glassman, Lionel, Box 735, Anton

Farms Road—8 †Glick, Samuel S., 3914 Park

Heights Avenue—15 Gluck, Francis W., 100 W. Uni-

versity Parkway—10 Gluck, Julius C., 5356 Reisterstown

Road—15 Goco, Romulo Valencia, 436 East Fort Avenue—30

Goldbach, Leo J., 6 E. Eager Street
—2

Goldberg, Herman Krieger, 807 Cathedral Street—1

Goldberg, Raymond B., 701 Cathedral Street—1

†Goldberg, Sigmund, 12 E. Pratt Street—2

†Goldberg, Sylvan D., 4412 Elderon Avenue—15

Goldberg, Victor, 1916 E. 30th Street—18

†Goldman, Abram, 2120 Western Run Drive—9

Goldman, Harris, 3507 Garrison Boulevard—15

†Goldmann, Harry, 2326 Eutaw Place—17

†Goldsborough, Charles R., 2923 St. Paul Street—18

†Goldstein, A. E., 3505 N. Charles Street—18

Goldstein, Marvin, 5334 Liberty Heights Avenue—7

†Goldstein, Robert Bruce, 806 Reverdy Road—12 Goldstone, Herbert, 1810 Eutaw Place—17

Golpira, Ataollah, 3705 Parkview Avenue—7

Golub, David Donald, 937 Brooks Lane—17

†Goodman, Howard, 8604 Harford Road—14 Goodman, Jerome Edward, 809

Cathedral Street—1 Goodman, Julius H., 3400 E. Balti-

more Street—24 †Goodman, Louis E., 1211 Eutaw

Place—17 †Goodman, Sylvan C., 3416 Old

Forest Road—8 Goodwin, Georgina Y., 6704 Max-

alea Drive—12 Gordon, Coral, 331 Tunbridge Road

—12 Gordon, Harry H., Sinai Hospital —15

Gordy, Lyle L., 5106 Harford Road

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Grabill, James R., 1945 W. Baltimore Street—23

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Greenwald, Leon, 1801 Eutaw Place—17

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Grenzer, William H., 1520 East 33rd Street—18

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Grose, William E., 1201 N. Calvert Street—2

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Grubb, Wilson, 3607 Greenway— 18

Grumbine, Francis L., 411 N. Chapelgate Lane—29

†Gubnitsky, Albert, 5415 Park Heights Avenue—15

†Guerin, Paul F., 100 North Calhoun Street-23

Gundersheimer, Herbert N., Cordova Apartments—17

Gundry, Lewis P., Relay-27

Gundry, Rachel K., Athol, Catons-ville—29

†Gutman, Isaac, 817 St. Paul Street

—2
Guttmacher, Carola B., 819 Park

Avenue—1
Guttmacher Manfred S 810 Park

Guttmacher, Manfred S., 819 Park
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Györkey, Ferenc, 4411 Bedford Place—18

Haase, John Henry, 2926 E. Cold Spring Lane—14

Hachtel, Frank W., 122 W. Lafayette Avenue—17

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†Hahn, Richard D., 1422 Park Avenue—17

†Haines, John S., 11 E. Chase Street —2

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†Hamburger, Louis P., 1001 St. Paul Street—2

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†Hankin Samuel I 3479 Liberty

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†Harbold, Harold Valentine, 4706 Harford Road—14

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Harris, Bernard, Jr., 1200 McCulloh Street—17

†Harris, Leroy C., Jr., 1106 Bellemore Road-10

Harrison, Clinton R., 1118 St. Paul Street—2 Harrison, Edmund P. H., 2903 N. Charles Street—18

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†Hartman, Oscar, 1719 Eutaw Place —17

Hartz, Jerome, 11 E. Chase Street—

Harvey, A. McGehee, Johns Hopkins Hospital—5

Harvey, John Collins, 410 Northway-18

Haskins, Arthur L., University Hospital—1

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Herold, Paul Garner, 1222 Walters Avenue—12

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†Highstein, Benjamin, 121 S. Highland Avenue—24

†Highstein, Gustav, 3415 Clarks Lane—15

Hill, Claude D., 3600 Wabash Avenue—15

Hills, Ralph G., 18 E. Eager Street
-2
Himelfarb, Albert J., 3501 St. Paul

Street—18 Hinno, Juri, 2900 Dunran Road—

†Hirschfeld, John H., 6919 Harford Road—14 Hobelmann, Charles F., 21 W. 27th Street—18

Hoffman, Elmer, 914 N. Charles Street—1

†Hoffman, Reuben, 3602 Forest Park Avenue—16

†Hogan, John F., 2 East Read Street—2

Hogan, John F., Jr., 2 East Read Street—2

†Hollander, David H., Montebello State Hospital—18

Holljes, Henry Wirt Duvall, 2 East Read Street—2

†Holmes, A. Clark, 4710 Mawani Road—6

Holt, Edward E., 3905 Duvall Avenue—16

Holzworth, Dorothy C., 9207 Satyr Hill Road—34

Hood, Bowman J., 317 Broxton Road—12

Hooper, Z. Vance, 3534 Ellerslie Avenue—18

Hoover, Richard E., 14 W. Mt. Vernon Place—1

Hope, Daniel, Jr., Braewood, S. Rolling Road—28

Hopf, Edward W., 3904 The Alameda—18

†Hopkins, H. Hanford, 1201 N. Calvert Street—2

Hopkins, James E. T., 205 W. Lanvale Street—17

Horine, Cyrus F., Medical Arts Building—1

Horning, Edward Douglas, 18 W. Franklin Street—1 Horton, William Preisz, 115

Witherspoon Road—12 Houpt, William P., 4920 Frankford

Avenue—6 †Houska, Henry John, 333 S. East Avenue—24

Howard, John Eager, Union Memorial Hospital—18

†Howard, John Tilden, 12 E. Eager Street—2

Huffer, Virginia, University Hospital—1

†Hull, Harry Clay, 521 Medical Arts Building—1

Hulla, Jaroslav, 2214 E. Fayette Street—31

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- Hurwitz, Chester E., 2218 Eutaw Place—17
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- †Hyman, Nathan B., 1805 Eutaw Place—17
- Iliff, Charles Edwin, 14 W. Mt. Vernon Place—1
- *Ingalls, George Sam, 703 Cathedral Street—1
- †Insley, James K., Jr., 2200 Mayfield Avenue—13
- Isaacs, Benjamin H., 1261 E. Belvedere Avenue—12
- Jackson, Dudley Pennington, The Johns Hopkins Hospital—5
- Jackson, Robert L., 600 North Arlington Avenue—17
- Jacobs, Louis Llewellyn, 3609 Labyrinth Road—15
- †Jacobson, Meyer W. 6821 Reisterstown Road—15
- Jahrreiss, Walter O., 6007 Lakeview Road—10
- James Walter E., 3534 Edmondson Avenue—29
- Jandorf, R. Donald, 6405 Western Run Drive—15
- Janney, Nathan, 7101 Harford Road—14
- Jarrett, Edwin B., 11 E. Chase Street—2
- †Jaworski, Melvin J., 2711 Eastern Avenue—24
- Jennings, F. Leslie, Medical Arts Building—1
- Jeppi, Joseph, 10 East Read Street

 —2
- Jeudy, Turgot, 520 N. Fulton Avenue—23
- Jewett, Hugh J., 1201 N. Calvert Street—2
- Johnson, Elliot W., 3432 Frederick Road—29
- Johnson, John Triplett Haxall, 4 East Madison Street—2
- †Johnson, Marius P., Medical Arts Building—1
- Johnson, Robert W., Jr., 4 E. Madison Street—2

- Johnson, Robert W., III, 1014 St. Paul Street—2
- Johnson, William R., Medical Arts Building—1
- Jones, Benjamin F., 1201 N. Calvert Street—2
- Jones, Everett D., 101 E. Biddle Street—2
- Jones, Georgeanna S., Medical Arts Building—1
- Jones, Grace G., Park Heights Avenue, Owings Mills P.O., Md. Jones, H. Alvan, 1107 St. Paul
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- Jones, Thomas Christopher, 1390 West North Avenue—17
- Josephs, David, Loch Raven Shopping Center, Loch Raven & Northern Parkway—12
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- †Kaltreider, D. Frank, 1526 Northwick Road—18
- Kammer, William H., Jr., 612 W. 40th Street—11
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- Kaplan, Irvin B., 129 S. Broadway —31
- †Kaplan, Isadore, 3314 Marnat Road—8
- Kappelman, Melvin Daniel, 817 St. Paul Street—2
- †Kardash, Theodore, 7700 York Road—4
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- Karns, James R., 800 Cathedral Street—1
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- Kates, Harry F., 517 Scott Street—
- Katz, Albert H., 3855 Forest Park Avenue—16
- Katzenberger, James W., 4123 Frederick Avenue—29 Kayser, Fayne A., Medical Arts
- Building—1

- Keller, Charles J., 222 W. Monument Street-1
- Kelly, Vernon C., 7215 York Road
 —12
- Kemick, Irvin B., 3736 Towanda Avenue—15
- Kemler, Joseph I., 2230 Park Avenue —17
- Kemp, Katherine V., 722 Stamford Road—29
- †Keown, Lauriston L., 431 E. Lake Avenue—12
- Kerman, Edward F., 11 East Read Street—2
- †Kern, Howard M., Esplanade Apartments—17
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- †Kiel, August, Jr., 1202 St. Paul Street-2
- †Kilby, Walter L., Medical Arts Building—1
- †Kimberly, Robert C., 1014 St. Paul Street—2
- †Kimmel, Louis E., Jr., 925 Lenton Avenue—12
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- Kleiman, Bernard S., 1113 North Calvert Street—2
- Kleiman, Norman R., 3803 Edmondson Avenue—29
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- †Klemkowski, Irvin P., 2 East Read Street—2
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†Klinefelter, Harry F., Jr., 1101 N. Calvert Street-2

Klohr, Edward Smith, Jr., 110 Knob Hill Court, Timonium, Md.

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Knipp, Harry Lester, 4116 Edmondson Avenue—29

Kochman, Leon A., 7945 Stevenson Road—8

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†Kravitz, Sheldon C., 2415 Kenoak Road—9

†Krejci, John J., 2 East Read St.—2 †Kremen, Abraham, 2355 Eutaw Place—17

†Krepp, Martin W., Jr., 1114 St. Paul Street—2

Kress, Milton B., Medical Arts Building—1

Krevans, Julius R., 5720 Uffington Rd.—9

Krieg, Edward L. J., 510 N. Chapel Gate Lane—29

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Krumrein, Louis F., 722 N. Kenwood Avenue—5

Kudirka, Justinas, 2151 Wilkens Avenue—23

†Kuehn, Frank G., 1511 Cranwell Rd., Lutherville, Md. Kunkowski, Andrew, 2529 Eastern Avenue—24

†Kurland, Albert A., 6207 Winner Avenue—15

Kyper, Fred T., 827 Park Avenue—1 †Lachman, Harry, 2322 Callow Ave. —17

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†Langenfelder, Henry E., 104 W. Madison Street—1

Langworthy, Orthello Richardson, 800 Malvern Avenue—4

Lapp, Herbert Walter, 4804 Frederick Avenue—29 Laukaitis, Joseph G., 679 Wash-

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Avenue—17 Leach, C. Edward, 14 E. Eager

Street—2 Lebo, Lester, 1801 Eutaw Place—17 †Le Doux, Clarence W., 3023 Eastern

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Road—27 Lee, Charles Dudley, Sr., 3300

Carlisle Avenue—16
Leeper, Lucius W., 1136 Poplar

Grove Street—16 Legge, John E., 700 Cathedral

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Drive—8

Leitz, T. Frederick, Temple Garden Apartments—17 Lenhard, Raymond E., 1107 St.

Paul Street—2 †Lerner, Philip F., 1111 St. Paul

Street—2
Leslie, Franklin Earl, 18 Charlcote

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-2 Levickas, Herbert J., 5305 East

Levin, H. Edmund, 3400 Hilton Road—15 Levin, Manuel, 4818 Reisterstown Road—15

†Levin, Milton, 2240 Eutaw Place —17

Levin, Morris Benjamin, 218 E. University Parkway—18

†Levin, Norman, 1 West Englemeade Road—8 Levine, Hilbert M., 405 Milford

Mill Road—8
Levine, Stuart C., 809 Cathedral
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†Levy, Kurt, 3103 North Charles Street—18

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Place—18
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Street—16 Michels, Joseph T., 11 E. Chase Street—2

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Street—2 Nowak, Sigmund R., 408 S. Patter-

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Park Avenue—1 †Proctor, Samuel E., 104 W. Madi-

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†Young, S. Earl, 148 N. Potomac Street, Hagerstown, Md.

Wicomico County

Adkins, Robert T., Fruitland P.O., Fruitland, Md.

Allen, Gladys, 224 North Division Street, Salisbury, Md.

Baker, Robert L., Medical Center, S. Salisbury Blvd., Salisbury, Md. Beardsley, Earl M., Maryland Ave-

nue, Salisbury, Md.

Bishop, James R., E. Main Street, Salisbury, Md.

Bloxom, John M., III, Medical Center, Salisbury, Md.

†Briele, Henry A., Medical Center, Salisbury, Md.

†Burton, Oswald J., 211 Maryland Avenue, Salisbury, Md.

Cayaves, Paul G., 222 N. Division Street, Salisbury, Md.

Christensen, Osborne D., 321 S. Division Street, Salisbury, Md.

Cooper, H. Douglas, Medical Center, Salisbury, Md.

Dumeyer, William, Peninsula General Hospital, Salisbury, Md.

Eccleston, H. N., Jr., Peninsula General Hospital, Salisbury, Md.

Ellis, Wilber R., Jr., Medical Center, Salisbury, Md.

Fisher, William Henry, Jr., Medical Center, Salisbury, Md.

Fitzgerald, Joseph C., 512 Elberta Avenue, Salisbury, Md.

Gallaher, James Patrick, Medical Center, Salisbury, Md.

Gardner, Rufus S., Jr., 321 S. Division Street, Salisbury, Md.

†Gillis, Marion Howard, Jr., 206 Walnut Street, Salisbury, Md.

^{*}Deceased. †Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

†Gilmore, David J., Medical Center, Salisbury, Md.

Gore, Robert J., Deers Head Hospital, Salisbury, Md.

Gramse, Fred R., 402 S. Division Street, Salisbury, Md.

†Gray, William David, 334 Camden Avenue, Salisbury, Md.

Hanson, I. Rivers, Medical Center, S. Salisbury Boulevard, Salisbury, Md.

Hearn, Carrie I., 226 N. Division Street, Salisbury, Md.

Hill, Thomas C., Pine Bluff Road, Salisbury, Md.

Howard, William L., 218 N. Division Street, Salisbury, Md.

Hurdle, Seth H., Wicomico Co. Health Dept., Watson Memorial Bldg., Salisbury, Md.

Insley, Philip A., East Main Street, Salisbury, Md.

Kolls, Alfred C., 742 South Park Drive, Salisbury, Md.

Kuhlman, Harry S., Sharptown, Md. Lawrence, Margaret, 226A West Main Street, Salisbury, Md.

Lawry, Lee L., Jr., Fruitland, Md. Ledermann, Alfred S., Medical Center, Salisbury, Md.

Lewis, Frank R., Willards, Md. †Long, William B., Medical Center,

Salisbury, Md. McCullough, Kendrick, Peninsula Gen. Hospital, Salisbury, Md.

Maldve, Leonid V., Deer's Head State Hospital, Salisbury, Md.

Mann, Hunter R., Jr., Maryland Avenue, Salisbury, Md.

Mattax, Henry McCoy, 711 Camden Avenue, Salisbury, Md.

Mitchell, Andrew C., 211 Maryland Avenue, Salisbury, Md.

†Morgan, W. C., Medical Center, Salisbury, Md.

Newman, A. Carleton, 704 Camden Avenue, Salisbury, Md.

Poole, Frank E., 111 Davis Street, Salisbury, Md.

†Purnell, E. A., 652 West Main Street, Salisbury, Md.

Reeves, Henry Gray, Medical Center, Pine Bluff, Salisbury, Md.

Ritchings, E. Peyton, Pine Bluff State Hospital, Salisbury, Md.

†Royer, Earl Lynwood, 407 Camden Avenue, Salisbury, Md.

Saunders, Richard H., Nanticoke, Md.

Sembly, G. Herbert, 400 E. Church Street, Salisbury, Md.

Smith, Stedman W., 706 Camden Avenue, Salisbury, Md.

Smith, William B., Medical Center, Salisbury, Md.

†Sohler, L. V., 303 East Street, Delmar, Md.

Sutter, Everett, Dames Quarter, Md. Tamasi, Joseph J., 911 Camden Avenue, Salisbury, Md.

Thompson, Ollie H., 604 Camden Avenue, Salisbury, Md.

Tymkiw, Stefan, Peninsula General Hospital, Salisbury, Md.

Wanner, Jesse R., Jr., 228 N. Division Street, Salisbury, Md.

Waters, Zack J., Medical Center, Salisbury, Md.

†Womack, William S., 706 Camden Avenue, Salisbury, Md.

†Yow, Raymond, 707 Camden Avenue, Salisbury, Md.

Worcester County

Cohen, Paul, Snow Hill, Md. Hamilton, C. Stanford, 212 Market Street, Pocomoke City, Md.

LaMar, Robert C., Snow Hill, Md. Robbins, Herman A., 5 Bay Street, Berlin, Md.

†Sartorius, Norman E., Pocomoke City, Md.

Sartorius, Norman E., Jr., Pocomoke City, Md.

†Schott, Clifford E., 310 N. Main Street, Berlin, Md.

†Thomas, Nathanael R., Philadelphia Avenue at 9th Street, Ocean City, Md.

Townsend, Francis J., Jr., Somerset Street, Ocean City, Md.

Trader, Charles W., 302 Market Street, Pocomoke City, Md.

Waesche, Fred S., Snow Hill, Md.

Affiliate Members

Anderson, George W., Providence Lying-in Hospital, Dir. of Laboratories, Providence 8, R. I.

Archibald, Reginald M., Hospital of the Rockefeller Institute for Medical Research, 66th Street and York Avenue, New York 21, N. Y.

Austrian, Robert, Kings County Hospital, F Bldg., Brooklyn 3, N. Y. Bacon, Robert B., Cedar Crest, 1905 Little River Turnpike, Fairfax, Va.

Baldi, Luigi, 71 First Avenue, Westwood, N. J.

Ballina, Jones B., 2249 N.W. 56th Street, Oklahoma City, Okla.

*Barrow, Bernard, Blackstone, Va. Belger, William T., Jr., Ministerial Branch, R.F.D. 2, Manchester, N. H.

Blain, Donald G., 841 Balfour Road, Grosse Pointe Park 30, Mich.

Brackin, John T., Jr., Abington Memorial Hospital, Abington, Pa.

Braun, Manfred, 345 W. 58th Street, Apt. 5-T, New York 19, N. Y.

Brimmer, Karl W., 1550 Miller Rd., Coral Gables, Fla.

Bronos, George J., 310 Maple Street, Holyoke, Mass.

Brown, Merrill W., 215 Oak, N.E., Albuquerque, N. Mex.

Bryan, Elizabeth Lynn, 146 Columbia Heights, Brooklyn 2, N. Y.

Byerly, William L., Jr., 905 Carolina Avenue, Hartsville, S. C.

Cantrell, James R., King County Hospital, Seattle 4, Wash.

Carroll, Charles F., Jr., 263 Grandview Drive, Concord, N. C.

Cavanagh, Denis, Jackson Memorial Hospital, Miami 36, Fla.

Cobb, John Candler, Box 124 A, South Sta. Rte., Sandoval, New Mex.

Codington, John B., 408 North 11th Street, Wilmington, N. C.

Cook, Sarah, 3103 10th Street, North, Arlington 1, Va.

Cope, Freeman W., 238 W. Court Street, Doylestown, Pa.

Copeland, Murray M., 6723 Bertner Street, Houston 25, Tex.

Dana, George W., Exec. Dir., Southwestern Foundation, Medical Arts Bldg., Dallas, Tex.

Davis, Bernard M., Jr., 117 North Claudina Street, Anaheim, Calif.

Devlin, Andrew J., Jr., First National Bank Bldg., Pullman, Wash.

Dickey, Francis G., Wood, Wis.

Elder, John D., Jr., Dept. of Anes., State Univ. of N. Y., College of Medicine, 451 Clarkson Avenue, Brooklyn, N. Y.

^{*}Deceased

[†]Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Farley, Julie, 2505 Cratchett Road, Wilmington 8, Del.

Farmer, William L., Jr., 8633 John Road, Detroit 2, Michigan.

Fitch, Charles Thomas, 1327 Torrey Pinos, LaJolla, Calif.

Freeman, Gustave, 1101 University Avenue, Palo Alto, Calif.

Futterman, Perry, Beckley Memorial Hospital, Beckley, W. Va.

Geiling, Eugene M. K., 800 Fourth Street S.W., Apt. N521, Washington 24, D. C.

Gerwig, Walter H., Chief of Surgery, Veterans Hosp., Clarksburg, W. Va.

Goldenthal, Sumner, 955 Ridge Road, Hamden 17, Connecticut.

Golji, Hossein, Golden Clinic, Elkins, W. Va.

Green, Charles R., Jr., 1101 Delaware Avenue, Wilmington, Del.

Greif, Roger Louis, Cornell Univ. Med. Center, 1300 York Avenue, New York 21, N. Y.

Griffith, Paul Condon, 4324 East 42nd Street, Seattle, Wash.

Haase, Frederick Robert, Medical Arts Building, Asbury Park, N. J. Hanchett, Richard B., 905 E. San

Antonio Drive, Long Beach, Calif. Hauber, Frank D., Currey Clinic, 205-07 Spears Avenue. Chatta-

205-07 Spears Avenue, Chattanooga, Tenn. Heinbach, Wilfred F. & Anne B.,

118 Main Street, Middleburg, Penna.

Heinlein, Christian Paul, 504 Forest Avenue, Greensboro, N. C.

Heisse, John W., Jr., 224 Crescent Road, Burlington, Vt.

Hendry, Marjorie H., 3532 A Street, S.E., Apt. 101, Washington 19, D. C.

Hoffmeister, Ferdinand S., Dept. of Reconstructive Surgery, Roswell Park Memorial Inst., Buffalo 3, N. Y.

Hook, Edward W., New York Hospital, Cornell Medical Center, 525
East 68th Street, New York 21,
N. Y.

Hopkins, John Vernon, 2505 Cratchett Road, Wilmington 8, Del.

Houman, Carl J., Empress Zauditu Memorial Hospital, P.O. Box 316, Addis Ababa, Ethiopia.

Jenkins, Rose D., 4123 South Edgehill Drive, Los Angeles, Calif. Johnson, Warren C., 2025 Eye Street, N.W., Washington 6, D. C.

Jones, Bryant L., Dir. Ciba Pharmaceutical Products, Inc., 556 Morris Avenue, Summit, N. J.

Jones, Thomas L., Research Associate, Wm. S. Merrell Co., Cincinnati 15, Ohio.

Kasle, Travis, 127 Ash Lane, Menlo Park, Calif.

Katims, Robert B., 1431 North Bayshore Drive, Miami, Fla.

Keeney, Edmund L., 476 Prospect Street, La Jolla, Calif.

Kopits, Imre, Spring Grove State Hospital, Baltimore 28, Md.

Kupfer, Carl, 15 Trowbridge Street, Cambridge, Mass.

Langeluttig, H. Vernon, Missouri State Sanatorium, Mt. Vernon, Mo.

Lasell, Eldridge L., 155 North Madison Avenue, Pasadena, Calif.

Latham, Ernest F., LCdr, USN, USS Franklin D. Rooosevelt, CVA 42, c/o FPO, New York, N. Y.

Lee, Lionel B. Q., 284 38th Street, Apt. 1, Oakland 11, Calif.

Lee, Thora W., 260 Poplar Drive, Oakville, Ontario, Canada.

Lipin, Raymond J., V.A. Hospital, 300 E. Roosevelt Road, Little Rock, Ark,

Liu, Wei-Chi, 4646 Marine Drive, Chicago 40, Ill.

Lukens, David, 415 W. 2nd Street, Hutchinson, Kans.

Lyford, John, III, Area Dir. Prof. Services, V.A.A.M. Office, 441-49 West Peachtree Street, Atlanta 8, Ga.

Lyon, William C., 2530 Beechwood Circle, Ft. Wayne, Ind.

McGeehan, James S., 1000 Oliver, Owosso, Mich.

McGrady, Kathleen R., 1919 Atlantic Boulevard, Box 426, Pompano, Fla

McKewen, Jane B., 406 Allegheny Avenue, Towson 4, Md.

McLean, Ross L., Dept. of Medicine, Emory University, 69 Butler Street, S.E., Atlanta 3, Ga.

Mattern, Elizabeth A., 13518 Grenoble Drive, Rockville, Md. Mirick, George S., Dir. New York City Health Research Council, 125 Worth Street, New York 13, N. Y.

Mitchell, Joshua R., III, P.O. Box 1030, Minden, La.

Mitchell, William Arthur, 106 E. Burke Avenue, Lufkin, Texas.

Molofsky, Leonard Carl, Kaiser Foundation Hospital, Broadway & McArthur Boulevard, Oakland 11, Calif.

Mooney, Albert Lee, 1139 Avenue B, Perry Point, Md.

Murphy, Maurice Joseph, 409-414 Second National Bank Bldg., Ashland, Ky.

Neff, Charles A., 1521 Martin, Porterville, Calif.

Noya, Joseph J., USPHS Hospital, New Orleans, La.

Owens, David, 561 Westwood Court, Vacaville, Calif.

Park, William F., 4705 State Road, Drexel Hill, Penna.

Patten, David H., Broutwood Road, Norwell, Mass.

Peachey, Ruth, 100 Passaic Avenue, Passaic, N. J.

Peirce, E. Converse, II, 4107 Tazewell Pike, Knoxville 18, Tenn. Petersdorf, Robert George, Kings

County Hospital, Seattle 4, Wash. Piper, Donald E., 117 W. Main Street, Dallastown, Pa.

Platt, George A., Elmwood Medical Bldg., 1351 Mt. Hope Avenue, Rochester 20, N. Y.

Plugge, Frederick W., IV, 1 South Street, New Haven 11, Conn.

Pratt, Daniel Wells, Hq. 24th Inf. Div., APO 112, New York, N. Y.

Proserpi, Sergio Vincent, 658 North 65th Street, Philadelphia, Penna.

Raskin, Howard Frank, Univ. of Chicago, Dept. of Med., Chicago 37, Ill.

Reichel, Samuel M., V.A. Hospital, Minneapolis 17, Minn.

Reynolds, Beverly Lee, University of Maryland Medical School, Baltimore 1, Md.

Rink, Heldi, c/o St. Clare's Hospital, Denville, N. J.

Risley, John P., 2305 Jackson Street, Waukegan, Ill.

Robinson, Daniel R., Area Med. Dir., V.A. Area Medical Office, 402 East State Street, Trenton, N. J.

- Rosenthal, Howard N., 1357 Bernal Avenue, Burlingame, Calif.
- Sabiston, David C., Jr., Address Unknown.
- Sadarananda, Vatana, P.O. Box 192, Bangkok, Thailand.
- Sanders, John A., 4000 Massachusetts Avenue, N.W., Suite 813, Washington, D. C.
- Scherr, Merle S., 803 Atlas Building, Charleston 1, W. Va.
- Seaton, Ronald S., St. Luke's Hospital, Vengurla Rathagiri Dist., B. S., India.
- Skaggs, James W., Jr., 130 Antiquera, Coral Gables 34, Fla.
- Slager, Ursula T., 2240 Buckingham Drive, Littleton, Colo.

- Smith, George W., Medical College of Georgia, Augusta, Ga.
- Sokol, Liebe Deborah, Hospital of Univ. of Pennsylvania, 3400 Spruce Street, Philadelphia, Pa.
- Sprunt, Katherine, 70 Haven Avenue, New York 32, N. Y.
- Steinberg, Stanley H., 8106 New Hampshire Avenue #101, Silver Spring, Md.
- Taxdal, David R., 1417 Lakeland Hills Boulevard, Lakeland, Fla.
- Teeter, James H., 117 West Main Street, Waynesboro, Penna.
- Thornhill, Joseph E., 49 South Munn Avenue, Newark, N. J.
- Virgilio, Frank D., U.S.N.H., Newport, R. I.

- Weitzman, Elliott L., Eastchester Road & Morris Park Avenue, New York 61, N. Y.
- Welsh, W. W., Gabbs, Nevada.
- Werbner, Izydor, 554 West Indianola Avenue, Youngstown 11, Ohio.
- Wolf, Frederick S., Det. #36, TUSLOG-USAF, APO 224, New York, N. Y.
- Wu, Jackson S., c/o Pathology Department, Scripps Memorial Hospital, La Jolla, Calif.
- Young, Leroy J., 547 N. Fair Oaks Avenue, Pasadena, Calif.
- Ziegler, Frederick J., 476 Prospect Street, La Jolla, Calif.

WIDOWS OF FORMER MEMBERS OF THE MEDICAL AND CHIRURGICAL FACULTY WHO ARE MEMBERS OF THE WOMAN'S AUXILIARY

- Abrams, Mrs. Michael A., 8305 Stevenson Road, Baltimore 8. Md.
- Ard, Mrs. Robert W., Rt. 6, Spring Valley, Md.
- Austrian, Mrs. Charles R., 1417 Eutaw Place, Baltimore 17, Md.
- Ball, Mrs. Peter, 1834 Glen Ridge Rd., Baltimore 4, Md. Barker, Mrs. Lewellys F., 208 Stratford Road, Baltimore 18, Md.
- Bauersfeld, Mrs. Emil G., 3916 Virgilia Street, Chevy Chase 15, Md.
- Binkley, Mrs. O. H., 444 Summitt Avenue, Hagerstown, Washington Co., Md.
- Brager, Mrs. Simon, 3705 North Charles Street, Baltimore 18. Md.
- Bridges, Mrs. W. A., 10 Othoridge Road, Towson 4, Md.
- Briele, Mrs. Myrtle G., 1506 Harford Rd., Baltimore 14, Md.
- Bubert, Mrs. John D., Wyman Park Apts., 506, Baltimore 1, Md.
- Fairchild, Mrs. S. R., 118 E. Magnolia Street, Hagerstown, Washington Co., Md.
- Foley, Mrs. Charles J., 400 S. Union Ave., Havre de Grace. Md.
- Fuller, Mrs. Harvey L., 5718 Ridgedale Road, Baltimore 9, Md.
- Gardner, Mrs. S. H., 56 Broadway, Hagerstown, Md.

- Hoffmeier, Mrs. Frank N., 442 N. Potomac Ave., Hagerstown, Washington Co., Md.
- Ingalls, Mrs. George Sam, 3 Club Road, Baltimore 10, Md.
- Jerardi, Mrs. Joseph V., 107 Armagh Drive, Baltimore 12, Md.
- 12, Md. Kloman, Mrs. Erasmus H., 600 Edgevale Rd., Baltimore
- Link, Mrs. V. Harwood, 947 Mulberry Avenue, Hagerstown, Washington Co., Md.
- Norment, Mrs. Richard B., Conococheague, Washington Co., Md.
- Sargent, Mrs. G. F., Aigburth Road, Towson 4, Md.
- Sinton, Mrs. William A., 1500 Ralworth Road, Baltimore 18, Md.
- Siscovick, Mrs. Milton, 3411 Edgewood Road, Baltimore 15, Md.
- Stewart, Mrs. George A., 5300 St. Albans Way, Baltimore 12, Md.
- Trescher, Mrs. John H., 9 St. Martin's Road, Baltimore 18, Md.
- Ward, Mrs. Grant E., 602 W. University Parkway, Baltimore 10, Md.
- Wells, Mrs. Samuel R., 1018 Potomac Avenue, Hagerstown, Washington Co., Md.
- Wroth, Mrs. Peregrine, Jr., 145 W. Prospect St., Hagerstown, Md.

COMMITTEE ROSTER

COMMITTEES ELECTED BY THE HOUSE OF DELEGATES

Beginning April 22, 1960 through Annual Meeting, 1961, as provided in the Constitution and Bylaws.

Committee on Scientific Work and Arrangements	A. Austin Pearre, Frederick
Term Expires*	J. Roy Guyther, Mechanicsville1963
William E. Grose, Chairman, Baltimore1961	Frederick J. Vollmer, Baltimore1964
Houston S. Everett, Baltimore	Lester A. Wall, Jr., Baltimore1965
James Douglas Lockard, Baltimore	Joseph C. Biddix, D.D.S.
Joseph B. Workman, Baltimore	Finney Fund Committee
gical Faculty, Baltimore (In conformity with Consti-	George G. Finney, Senior Member, Baltimore 1961
tution and Bylaws.)	Richard G. Coblentz, Baltimore1962
Library Committee	Richard T. Shackelford, Baltimore
Louis Krause, Chairman, Baltimore1961	Henry J. L. Marriott, Baltimore1965

COUNCIL APPOINTMENTS

Curator: Walter D. Wise

The Maryland State Medical Journal George H. Yeager, Editor, Baltimore

Editorial Board	Term Expires		
Hugh J. Jewett, Baltimore	Decembe	r 31,	1960
William B. Long, Salisbury	Decembe	r 31,	1960
Ephraim T. Lisansky, Baltimore	Decembe	r 31,	1961
Edward C. H. Schmidt, Easton	Decembe	r 31,	1961
Howard M. Bubert, Baltimore	Decembe	r 31,	1962
Amos R. Koontz, Baltimore	Decembe	r 31,	1962
Mr. John Sargeant, Executive Secreto	ry, Balt	imore	

Representatives on Advisory Committee on Adoption of the State Department of Welfare

(Appointed by the President, upon authorization of Council, in December 1957, at request of Director of State Department of Public Welfare.) Wilson Grubb, Baltimore

D. Frank Kaltreider, Baltimore

Representatives on the Medical Advisory Committee of the Red Cross Blood Bank Program

(Appointed by the President.) C. Lockard Conley, Baltimore R Adams Cowley, Baltimore Everett S. Diggs, Baltimore Gerald A. Galvin, Baltimore

President of the Medical and Chirurgical Faculty, ex officio member

Representatives on State Advisory Committee on Staphylococcal Disease in Maryland (Appointed by the President November 21, 1958 at the

*Term expires at conclusion of annual meeting of year indicated.

request of Dr. Perry F. Prather, Director of the State Department of Health as an outcome of the National Conference on Hospital Acquired Staphylococcal Disease held September 1958.)

Daniel J. Pessagno, Baltimore John M. Haws, Baltimore

> Medical Advisory Committee on Vocational Rehabilitation

(Upon request of Department of Education, representatives were recommended by Executive Committee in February 1957, and duly approved by State Department of Education.)

Florence I. Mahoney, Baltimore

Douglas G. Carroll, Jr., Brooklandville

Maurice C. Pincoffs, Baltimore

Albert I. Mendeloff, Baltimore

Charles Reifschneider, Baltimore

Francis J. Borges, Baltimore

Leroy W. Saunders, Baltimore

Howard B. McElwain, Baltimore

Advisory Committee to the Woman's Auxiliary Through Annual Meeting 1961

(Upon recommendation of Council, in May 1956 the House of Delegates authorized that the Executive Committee of the Council be the Advisory Committee to the Woman's Auxiliary.)

Charles F. O'Donnell, Chairman, Baltimore. M. McKendree Boyer, Vice-Chairman, Damascus

Whitmer B. Firor, President, Baltimore

Howard F. Kinnamon, President-elect, Easton

William Carl Ebeling, Secretary, Baltimore Wetherbee Fort, Treasurer, Baltimore

CONSTITUTIONAL COMMITTEES

(As Provided in the Constitution and Bylaws. Term expires at conclusion of 1961 Annual Meeting unless otherwise designated.)

Committee on Constitution and Bylaws

(In conformity with the Bylaws, consists of four members to be appointed annually by the President.)
William A. Pillsbury, Jr., Chairman, Timonium
Waldo B. Moyers, Hyattsville
Edwin H. Stewart, Jr., Baltimore
Arthur J. Weinberg, Baltimore

Executive Committee of the Council (Chairman of the Council, Vice-Chairman of the

Council, President, Secretary and Treasurer.)
 Charles F. O'Donnell, Chairman of Council, Baltimore
 M. McKendree Boyer, Vice-Chairman of Council, Damascus

Whitmer B. Firor, *President*, Baltimore Howard F. Kinnamon, *President-elect*, Easton William Carl Ebeling, *Secretary*, Baltimore Wetherbee Fort, *Treasurer*, Baltimore

The House Committee

(Executive Committee plus the Chairman of the Library Committee as provided in the Constitution and Bylaws.)

Charles F. O'Donnell, Chairman of Council, Baltimore M. McKendree Boyer, Vice-Chairman of Council, Damascus

Whitmer B. Firor, *President*, Baltimore William Carl Ebeling, *Secretary*, Baltimore Wetherbee Fort, *Treasurer*, Baltimore

Louis Krause, Chairman of Library Committee, Baltimore

Committee on Finance and Budget

(In accordance with the Bylaws, shall consist of nine members; namely, Chairman of Council, Vice-Chairman of Council, the Treasurer, who shall be Chairman of Committee, the Secretary, Chairman of Planning Committee, and four additional members appointed by Chairman of Council.)

Wetherbee Fort, Treasurer, Chairman, Baltimore Charles F. O'Donnell, Chairman of Council, Baltimore M. McKendree Boyer, Vice-Chairman of Council, Da-

William Carl Ebeling, Secretary, Baltimore
William A. Pillsbury, Jr., Chairman of Planning Committee, Timonium

Howard B. Mays, Baltimore Albert E. Goldstein, Baltimore John W. Parsons, Baltimore R. Walter Graham, Jr., Baltimore

Nominating Committee

(In conformity with the Bylaws, Chapter X, Section 5, this Committee shall consist of 7 members. The immediate Past President shall be the Chairman and the President

dent shall appoint one member from each of the 5 districts and one at large. No member may serve more often than every 5 years unless death or resignation makes necessary the immediately preceding Past President serving again.)

THE NOMINATING COMMITTEE IS APPOINTED AT A LATER DATE.

Professional Conduct Committee

Through Annual Meeting 1961

(Five living immediate Past Presidents and Chairman of the Council, with the Senior Past President as Chairman, and each Past President to serve for five years on Committee.)

George H. Yeager, Chairman, (President in 1955), Baltimore

William H. F. Warthen (President in 1956), Towson
C. Reid Edwards (President in 1957), Baltimore
J. Sheldon Eastland (President in 1958-59), Baltimore
Leslie E. Daugherty, (President in 1959-60), Cumberland

Charles F. O'Donnell, (Chairman of Council 1960-61), Baltimore

Planning Committee

Through Annual Meeting 1961

(Authorized by the House of Delegates, May 1956, and appointed formally June 1956. In conformity with the Bylaws as of September 1957, the Planning Committee shall consist of the President, Secretary, Treasurer, Chairman of Council, Vice-Chairman of Council, and one Representative elected annually by each Component Society.)

William A. Pillsbury, Jr., Chairman, Baltimore County Alternate: Charles F. O'Donnell

Richard D. Bauer, Vice-Chairman, Prince George's County

Whitmer B. Firor, President
William Carl Ebeling, Secretary
Wetherbee Fort, Treasurer
Charles F. O'Donnell, Chairman of Council
M. McKendree Boyer, Vice-Chairman, Council
Benedict Skitarelic, Allegany-Garrett County
Alternate: Martin M. Rothstein
Merton T. Waite, Anne Arundel County

Alternate: Richard N. Peeler Conrad Acton, Baltimore City Alternate: Russell S. Fisher Hugh W. Ward, Calvert County Edwin G. Riley, Caroline County Alternate: Dawson O. George Morrell Mastin, Carroll County Alternate: Charles L. Billingslea

H. Vincent Davis, Cecil County Edward J. Edelen, Charles County Alternate: John H. Griffin

CONSTITUTIONAL COMMITTEES, Continued

Planning Committee, Continued

George E. Currier, Dorchester County

Alternate: Frederick A. Miller

James B. Thomas, Frederick County

J. Ralph Horky, Harford County Theodore R. Shrop, Howard County

A. C. Dick, Kent County

Aaron H. Traum, Montgomery County

Alternate: Henry P. Laughlin

Irvin G. Hoyt, Queen Anne's County Alternate: Theodor Sattelmaier

Julian Lane, St. Mary's County

Sarah M. Peyton, Somerset County

A. B. Cecil, Jr., Talbot County

Alternate: John Sommerfield Green, III

Dalton Welty, Washington County

Philip A. Insley, Wicomico County

Alternate: John M. Bloxom, III

Paul Cohen, Worcester County

Alternate: Norman E. Sartorius, Jr. Resolutions Committee

(In conformity with the Bylaws, five members to be appointed annually by the President of the Medical and Chirurgical Faculty, who shall also designate the

Chairman.)

Everett S. Diggs, Chairman, Baltimore

M. McKendree Boyer, Damascus

Ernest I. Cornbrooks, Jr., Baltimore

Melvin B. Davis, Dundalk

Robert W. Farr, Chestertown

APPOINTED BY THE PRESIDENT

Representative on Legislative Council's

Subcommittee on Narcotics

(Requested by Senator George B. Rasin, June 15, 1960, and W. B. Firor, M.D., the President, made this appointment. "The term of office would be that of the Legislative Council.")

John T. King, Baltimore

National Foundation of Health Scholarships Representative

(The President, each year upon request from the Foundation, submits the names of three nominees from which one may be selected by the Foundation to serve on the State Committee. Requested the first time in Feb. 1959.)

W. Houston Toulson, Baltimore

CONTINUING COMMITTEES

Beginning April 22, 1960 to serve through the Annual Meeting, 1961. Appointed by the President unless otherwise designated. Many of these committees are appointed in accordance with specifications that designate personnel.

Liaison Committee on Accreditation of Hospitals and Intern and Residency Training Programs

(Appointed as a Continuing Committee by the Chairman of the Council, as authorized by the Council, June

Howard W. Jones, Jr., Chairman, Baltimore

Robert L. Baker, Salisbury

Lewis P. Gundry, Baltimore

Amos R. Koontz, Baltimore

Louis Krause, Baltimore

Edmond J. McDonnell, Baltimore

Samuel Morrison, Baltimore

William S. Murphy, Rockville

E. Roderick Shipley, Baltimore

Stedman W. Smith, Salisbury

Lester A. Wall, Jr., Baltimore (The following were selected by the hospitals, as indicated, to serve on this Committee.)

Warde B. Allan, (Johns Hopkins), Baltimore

Reuben Andres, (Baltimore City), Baltimore Emidio A. Bianco, (St. Agnes), Baltimore

John N. Classen, (Union Memorial), Baltimore

J. Sheldon Eastland, (Mercy), Baltimore C. Thomas Flotte, (Maryland General), Baltimore

Sylvan D. Goldberg, (Church Home), Baltimore

Albert J. Himelfarb, (Sinai), Baltimore

W. Kenneth Mansfield, (Franklin Square), Baltimore Samuel Morrison, (Women's), Baltimore

Thomas R. O'Rourk, (Balto. Eye, Ear & Throat), Baltimore

Salvador Rosello (Lutheran), Baltimore

William J. Supik, (St. Joseph's), Baltimore

E. David Weinberg, (South Balto. General), Baltimore Alvin P. Wenger, (Presbyterian Eye, Ear & Throat),

Earle M. Wilder, (North Charles General), Baltimore

Committee on Aging

(Formerly Geriatrics Committee and House of Delegates, April 20, 1960, authorized that the name be changed.) C. Rodney Layton, Chairman, Centreville Archie Robert Cohen, Clear Spring Amos R. Koontz, Baltimore Louis Krause, Baltimore Isadore B. Lyon, Hagerstown William H. Woody, Baltimore

Faculty Representatives on the Maryland Joint Council to Improve the Health of the Aged Archie Robert Cohen, Clear Spring Louis Krause, Baltimore C. Rodney Layton, Centreville

Committee to Cooperate with the American Medical Education Foundation

William S. Stone, Chairman, Baltimore

Albert L. Anderson, Annapolis David J. Gilmore, Salisbury J. Roy Guyther, Mechanicsville W. Royce Hodges, Jr., Cumberland Lauriston L. Keown, Baltimore Bender B. Kneisley, Hagerstown Shepherd Krech, Easton George J. Kreis, Jr., Elkton

Waldo B. Moyers, Hyattsville James A. Roberts, Silver Spring Thomas B. Turner, Baltimore

Building Committee Albert E. Goldstein, Chairman, Baltimore

John W. Parsons, Treasurer, Baltimore Everett S. Diggs, Baltimore E. W. Ditto, Jr., Hagerstown

J. Sheldon Eastland, Baltimore R. Walter Graham, Jr., Baltimore William B. Long, Salisbury

S. Herbert Mueller, Jr. Parkton Charles F. O'Donnell, Baltimore

James H. Ramsay, Hagerstown

Austin B. Rohrbaugh, Jr., Chevy Chase

Committee on Diabetes

Abraham A. Silver, Chairman, Baltimore John Howard Burns, Jr., Dundalk Caroline H. Callison, Centreville Charles R. Campbell, Baltimore Henry V. Chase, Frederick J. Wilfred Davis, Baltimore Richard C. Dodson, Rising Sun J. Sheldon Eastland, Baltimore Edward J. Edelen, La Plata Robert W. Farr, Chestertown Sylvan D. Goldberg, Baltimore Wilson Grubb, Baltimore

J. Roy Guyther, Mechanicsville W. Grafton Hersperger, Baltimore Philip W. Heuman, Bel Air Henry J. Houska, Baltimore Seth H. Hurdle, Salisbury Benjamin F. Jones, Baltimore Crawford N. Kirkpatrick, Jr., Baltimore Harry L. Knipp, Baltimore E. Paul Knotts, Denton Frank E. Leslie, Baltimore J. Emmett Queen, Crisfield Theodore R. Shrop, Ellicott City Stanley R. Steinbach, Baltimore Samuel J. N. Sugar, Mt. Rainier J. Frank Supplee, III, Baltimore Nathanael R. Thomas, Ocean City James U. Thompson, Cambridge Alice B. Tobler, Baltimore Robert W. Trever, Easton Stephen J. Van Lill, Baltimore Lester A. Wall, Jr., Baltimore

Fee Schedule Committee

William G. Speed, III, Chairman, Baltimore Katherine H. Borkovich, Baltimore

Maryland Society on Internal Medicine Charles N. Davidson, Baltimore

Maryland Radiological Society Louis C. Dobihal, Baltimore

Maryland Chapter, American Academy of General Practice

Leonard J. Gallant, Baltimore Maryland Psychiatric Society

George H. Greenstein, Baltimore

Orthopedic, Section, Baltimore City Medical Society Wilson Grubb, Baltimore

Maryland Chapter, American Academy of Pediatrics

Alfred T. Lieberman, Baltimore

Otolaryngolical Section, Balto. City Medical Society William V. Lovitt, Jr., Towson

Maryland Society of Pathologists

Howard B. Mays, Baltimore

Maryland Chapter, American Urological Society

Frank K. Morris, Baltimore

The Obstetrical & Gynecological Society of Maryland

William H. Mosberg, Jr., Baltimore Maryland Chapter, American College of Surgeons

Howard A. Naquin, Baltimore

Ophthalmological Section, Baltimore City Medical Society

Alfred T. Nelson, Baltimore

Maryland Society of Anesthesiologists

John F. Strahan, Baltimore

Dermatology Section, Baltimore City Medical Society

Industrial Health Committee

Donald Roop, Chairman, Baltimore

William F. Cox, III, Baltimore

CONTINUING COMMITTEES, Continued

Industrial Health Committee, Continued

J. Sheldon Eastland, Baltimore Walter E. Fleischer, Baltimore James Frenkil, Baltimore Herman J. Halperin, Baltimore F. Ford Loker, Baltimore Howard B. McElwain, Baltimore Nathan E. Needle, Baltimore Harry M. Robinson, Jr., Baltimore Benjamin H. Rutledge, Baltimore

Legislative Committee

(Each Component Society is represented by the incumbent President, Secretary and Treasurer, and also the Chairman of the Legislative Committee of the Baltimore City Medical Society, Newland E. Day, who was appointed for 1960.) Karl F. Mech, Chairman, Baltimore Frederic V. Beitler, Relay Henry A. Briele, Salisbury

F. Ford Loker, Baltimore John A. O'Connor, Baltimore John Mace, Jr., Cambridge J. Morris Reese, Baltimore

Maternal and Child Welfare Committee

J. Morris Reese, Chairman, Baltimore T. Terry Burger, Vice-Chairman, Baltimore John A. Askin, Baltimore Harry D. Bowman, Hagerstown Caroline A. Chandler, Baltimore Stuart Christhilf, Jr., Annapolis Raymond L. Clemmens, Baltimore George H. Davis, Baltimore D. McClelland Dixon, Baltimore H. W. Eliason, Cumberland Abraham H. Finkelstein, Baltimore Paul Harper, Baltimore John S. Haught, Mt. Rainier Frederick J. Heldrich, Jr., Frederick D. Frank Kaltreider, Baltimore William H. Lawson, Eldersburg G. Bowers Mansdorfer, Baltimore William C. Morgan, Salisbury Dexter L. Reimann, Baltimore John E. Savage, Baltimore William M. Seabold, Baltimore Fred B. Smith, Baltimore F. X. Paul Tinker, Glen Burnie Gibson J. Wells, Baltimore Benjamin D. White, Baltimore John Whitridge, Jr., Baltimore

> Joint Committee with the Bar Associations on Medicolegal Problems

Russell S. Fisher, *Chairman*, Baltimore Conrad Acton, Baltimore

Lewis P. Gundry, Baltimore William D. Lynn, Baltimore George McLean, Baltimore M. C. Porterfield, Hampstead John F. Schaffer, Baltimore Richard T. Shackelford, Baltimore Benedict Skitarelic, Cumberland W. Kennedy Waller, Baltimore John M. Warren, Laurel Huntington Williams, Baltimore

Mental Hygiene Committee

(The President appoints members to this Committee for a term of three years, and at least one is replaced annually. Term expires at conclusion of Annual Meeting in year indicated.)
Kent E. Robinson, Chairman, Baltimore (1963)
Harry M. Murdock, Towson (1961)
Richard H. Pembroke, Jr., Baltimore (1961)
Sarah S. Tower, Baltimore (1961)
Isadore Tuerk, Catonsville (1961)
James S. Whedbee, Jr., Baltimore (1962)
William W. Magruder, Baltimore (1962)
Richard W. Trevaskis, Jr., Cumberland (1962)
Richard H. Doss, Baltimore (1963)
James A. Meath, Baltimore (1963)

Committee on National Emergency Medical Service I. Ridgeway Trimble, Chairman, Baltimore John Edward Adams, Baltimore John G. Ball, Bethesda Robert C. Kimberly, Baltimore Shepard Krech, Jr., Easton Julius R. Krevans, Baltimore Abraham J. Mirkin, Cumberland Russell H. Morgan, Baltimore Perry F. Prather, Baltimore John F. Schaefer, Baltimore Lawrence M. Serra, Baltimore J. Frank Supplee, Baltimore Philip Whittlesey, Baltimore Huntington Williams, Baltimore James K. V. Willson, Baltimore

Medical Advisory Committee to Bureau of Old Age and Survivors Insurance (Appointed by the President, October 1957, upon au-

thorization of Council at request of House of Delegates of A.M.A.)
J. Frank Supplee, III, *Chairman*, Baltimore
William G. Helfrich, Baltimore
George O. Himmelwright, Cumberland
Lloyd E. Saylor, Baltimore

Committee for the Study of Pelvic Cancer Howard W. Jones, Jr., Chairman, Baltimore William K. Diehl, Vice-Chairman, Baltimore Thomas S. Bowyer, Baltimore

Committee for the Study of Pelvic Cancer, Continued

John C. Dumler, Baltimore Gerald A. Galvin, Baltimore Arthur L. Haskins, Baltimore Theodore Kardash, Baltimore Charles B. Marek, Baltimore Paul E. Molumphy, Baltimore Frank K. Morris, Baltimore Edward H. Richardson, Baltimore Isadore A. Siegel, Baltimore A. A. Sondheimer, Baltimore Richard W. TeLinde, Baltimore J. Donald Woodruff, Baltimore

Committee to Study Problems of Mutual Interest to the Medical and Chirurgical Faculty and the Maryland Pharmaceutical Association

(Appointed in 1955, as authorized by Council April 1955 at the request of the Professional Relations Committee of the Maryland Pharmaceutical Association.)
Edward F. Cotter, *Chairman*, Baltimore
Edwin B. Jarrett, Baltimore
Martin L. Singewald, Baltimore
Henry J. L. Marriott, Baltimore

Committee on Rural Health

(Upon authorization of House of Delegates, May 1957, Committee to be comprised of seven members, one new member being added each year, the Chairman being dropped and thus each member will in this manner work up to Chairmanship in final year of service.)
Gordon M. Smith, Chairman, Barnesville (1961)
C. Rodney Layton, Centreville (1962)
S. Ralph Andrews, Elkton (1963)
James G. Sasscer, Upper Marlboro (1964)
Archie Robert Cohen, Clear Spring (1965)
Page C. Jett, Prince Frederick (1966)
Henry V. Chase, Frederick (1967)

Advisory Committee to the State Accident Fund

George O. Eaton, Chairman, Baltimore James G. Arnold, Jr., Baltimore Carlton Brinsfield, Cumberland Charles N. Davidson, Baltimore Jason H. Gaskel, Baltimore F. Ford Loker, Baltimore Howard B. McElwain, Baltimore Daniel J. Pessagno, Baltimore William A. Pillsbury, Baltimore

Committee to Consult with the State Department of Health

(The Committee to consist of the President, the President-elect, two Past Presidents, the Secretary and four

general practitioners, appointed by the President, of which one represents the Maryland Academy of General Practice.)
Leslie E. Daugherty, *Chairman*, Cumberland (Past-President April 1959-April 1960)
J. Sheldon Eastland, Baltimore (Past-President April 1958-April 1959)

Whitmer B. Firor, Baltimore (President April 1960-April 1961) Howard F. Kinnamon, Easton (President-elect April 1960-April 1961)

William Carl Ebeling, Baltimore (Secretary April 1960-April 1961)

Four General Practitioners
Walter A. Anderson, Baltimore
(Maryland Academy of General Practice)
Wilbur H. Foard, Manchester
Phillip C. Heuman, Bel Air
Francis J. Townsend, Ocean City

Tuberculosis Committee

William S. Spicer, Chairman, Baltimore Edmund G. Beacham, Baltimore R Adams Cowley, Baltimore Wyand F. Doerner, Cumberland A. Murray Fisher, Baltimore Leon H. Hetherington, Baltimore Meyer William Jacobson, Baltimore Richard F. Kieffer, Jr., Baltimore Milton B. Kress, Baltimore John E. Miller, Baltimore William Newcomer, Mt. Wilson William F. Rienhoff, III, Baltimore Moses S. Shiling, Baltimore Charlotte Silverman, Baltimore

Student American Medical Association Representative

(Appointed December, 1958, by President, for two year term of office.) Lewis P. Gundry, Baltimore

Committee on Veterans' Medical Care

Amos R. Koontz, Chairman, Baltimore Ernest I. Cornbrooks, Jr., Baltimore Philip D. Flynn, Baltimore Arthur Karfgin, Baltimore Andrew E. Mance, Oakland Clarence E. McWilliams, Reisterstown S. Edwin Muller, Baltimore Blaine M. Schindler, Cumberland William B. VandeGrift, Baltimore George H. Yeager, Baltimore

SPECIAL COMMITTEES

Appointed by House of Delegates, Council, Executive Committee or Current President to study a special problem. Only change of personnel to be at the request of the committee as a whole. Committee discharged when specific study is completed.

Committee on Prevention of Automotive Highway Disasters

(Appointed by the President as authorized by the House of Delegates, May 1957.)
James McC. Finney, Chairman, Havre de Grace Russell S. Fisher, Baltimore
Philip A. Insley, Salisbury
Fdmond J. McDonnell, Baltimore
A. J. Mirkin, Cumberland
A. Austin Pearre, Frederick
John J. Tansey, Baltimore

Committee on Hospital Use of Blue Shield Restricted

(Appointed by Council, June 1959.)
William L. Garlick, Chairman, Baltimore
Thurston Harrison, Easton
William D. Lynn, Baltimore
Samuel Morrison, Baltimore
John W. Parsons, Baltimore
Alexander J. Schaffer, Baltimore

Charles Conrad Zimmerman, Cumberland

Special Committee on Blue Cross/Blue Shield Legislative Study

(Appointed by the President. Authorized by the Executive Committee July 28, 1959 and ratified by Council, August 6, 1959.) William Carl Ebeling, Chairman, Baltimore M. McKendree Boyer, Damascus Archie R. Cohen, Clear Spring Charles N. Davidson, Baltimore Everett S. Diggs, Baltimore H. W. Eliason, Cumberland Gerald A. Galvin, Baltimore Paul F. Guerin, Baltimore J. Roy Guyther, Mechanicsville William B. Hagan, Mt. Rainier Charles F. Hobelmann, Baltimore J. Ralph Horky, Churchville John H. Hornbaker, Hagerstown John Tilden Howard, Baltimore Howard F. Kinnamon, Easton

Howard F. Kimamon, Easton
Howard B. Mays, Baltimore
(Also member Blue Cross Board)
A. Austin Pearre, Frederick
J. Morris Reese, Baltimore
Bernard W. Sollod, Baltimore
Martin E. Strobel, Reisterstown
W. Alfred Van Ormer, Cumberland
(The Council January 19, 1960, authorize

(The Council, January 19, 1960, authorized that the Faculty appointees on the Blue Cross/Blue Shield Boards become members of this Committee.)

Conrad Acton, Baltimore
Edgar T. Campbell, Hagerstown
J. Sheldon Eastland, Baltimore
Thurston Harrison, Easton
Page C. Jett, Prince Frederick
C. Rodney Layton, Centreville
Charles O'Donovan, Jr., Baltimore
Edward H. Richardson, Jr., Baltimore
John E. Savage, Baltimore
Martin L. Singewald, Baltimore
Arthur Woodward, Rockville

Committee to Investigate Group Insurance on a State-Wide Basis and Professional Liability Advisory Committee

(Appointed by the President of the Faculty on authority of the House of Delegates, September 1956.)
Frank F. Lusby, Chairman, Hagerstown
J. Tyler Baker, Easton
M. McKendree Boyer, Damascus
Wolcott L. Etienne, College Park
John N. Robinson, Easton

Committee to Review Proposed Regulations on Hospital Licensing

(Appointed on authority of Council by its Chairman July 1956, as requested by State Department of Health.) Harry F. Klinefelter, *Chairman*, Baltimore J. Oliver Purvis, Annapolis I. Ridgeway Trimble, Baltimore

Committee to Confer with Insurance Carriers in Regard to Problem of Specialties—Radiology, Pathology, Anesthesiology

(Appointed by the Council upon authorization of recommendation adopted by the House of Delegates September 1955.)
Edgar T. Campbell, Chairman, Hagerstown
Webster H. Brown, Baltimore
George G. Finney, Baltimore

I. Rivers Hanson, Salisbury Walter C. Merkel, Baltimore

Committee to Consult with Labor Leaders and Unions of Maryland

(Appointed by Chairman of Council as authorized by Council, June, 1957.)
Warfield, M. Firor, Chairman, Baltimore
William A. Pillsbury, Jr., Co-Chairman, Timonium
C. Reid Edwards, Baltimore
J. Elliot Levi, Baltimore
Clarence E. McWilliams, Reisterstown
Charles F. O'Donnell, Towson

Medical Economics Committee

(The Chairman of Council and the Chairman of the Planning Committee, as of January, 1959, appointed said Committee.)

- * Robert C. Kimberly, Chairman, Baltimore
- * Richard D. Bauer, Hyattsville
- * A. C. Dick, Chestertown
- § Everett S. Diggs, Baltimore
- § William B. Hagan, Mt. Rainier
- * J. Ralph Horky, Churchville
- * Philip A. Insley, Salisbury
- § R. Carmichael Tilghman, Baltimore

Medical Advisory Committee for the Medicare Program

(Council authorized the Executive Committee to appoint this Committee, December 1956.) Wilson Grubb, Chairman, Baltimore Robert Lee Baker, Salisbury Stuart M. Christhilf, Annapolis James McC. Finney, Havre de Grace Herbert N. Gundersheimer, Baltimore Gustav Highstein, Baltimore W. Royce Hodges, Cumberland John H. Hornbaker, Hagerstown Amos R. Koontz, Baltimore John M. Spence, Baltimore Bernard O. Thomas, Jr., Frederick Roger S. Waterman, Randallstown John Dean Wilson, Hagerstown Worth B. Daniels, Jr., Baltimore

Committee on Public Instruction

Harry M. Robinson, Jr., Chairman, Baltimore J. Sheldon Eastland, Baltimore Thomas F. Herbert, Ellicott City James G. Howell, Baltimore Lauriston L. Keown, Baltimore Henry P. Laughlin, Chevy Chase William T. Layman, Hagerstown E. T. Lisansky, Baltimore James R. Martin, Annapolis Richard B. Norment, III, Havre de Grace E. Roderick Shipley, Baltimore Hugh M. Ward, Owings John M. Warren, Laurel Huntington Williams, Baltimore Richard J. Williams, Cumberland * Selected by Chairman, Planning Committee.

§ Selected by Chairman, Council.

Committee to Consider the Relationship Between Hospitals and Specialties and the Manner of Payment for Professional Services

(Appointed in 1951, as authorized by Council February 1951. The last one appointed by Maryland-District of Columbia-Delaware Hospital Association.)
Webster H. Brown, Chairman, Baltimore
E. Hollister Davis, Baltimore
Henry L. Wollenweber, Baltimore
A. Dougal Young, Baltimore
Mr. Harvey H. Weiss, Baltimore

The 1960 Transactions will be concluded in the September 1960 issue of the Maryland State Medical Journal.

MBE

^{*} Selected by Chairman, Planning Committee. § Selected by Chairman, Council.